Cluster Evaluation of the Community-Based Public Health Initiative: 1995 Annual Report

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Center for Urban and Regional Affairs
University of Minnesota
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Minneapolis, Minnesota 55455

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CBPH at a Glance

The Community-Based Public Health initiative was designed to "assist communities, academic programs, and local health agencies to develop joint models for community-based education, research, and service." Four-year grants were awarded in 1992 to seven consortia in the U.S.

Time Period:
1991 - 92 Phase I, Leadership and Model Development
1992 - 93 1st year of Phase II, Implementation (10/1/92 start date)
1993 - 94 2nd year of Phase II, Implementation
1994 - 95 3rd year of Phase II, Implementation

Program Directors: Dr. Thomas A. Bruce and Dr. Steven Uranga McKane

Cluster Evaluation Team: University of Minnesota, Center for Urban & Regional Affairs
Dr. Constance C. Schmitz, Principal Investigator (Coordinator)
Consultants: Ms. Carol McGee Johnson, Mr. Arthur Himmelman, Dr. Marijo Wunderlich, and Dr. Michael Luxenberg
Research Assist: Ms. Cecilia Goetz and Mr. Dung Truong
Subcontracts: Minnesota Center for Survey Research
Grey Lizard Productions, Inc.

Funded Consortia: California, Georgia, Maryland, Massachusetts, Michigan, North Carolina, Washington

Organizations:
N = 24 Academic institutions, schools, or programs
N = 19 Public health practice departments, agencies
N = 31 Community-based organizations, groups

Number of Participants: N = 271 active members (as of 6/2/95)

Fiscal Agents:
University of Massachusetts, Amherst, MA
Berkshire Area Health Education Center, Pittsfield, MA

University of North Carolina, Chapel Hill, NC

Alameda Health Consortium, Oakland, CA

Group Health Cooperative of Puget Sound, Seattle, WA

Johns Hopkins University, Baltimore, MD
Clergy United for the Renewal of East Baltimore, MD

University of Michigan, Ann Arbor, MI

Cobb County Board of Health, Marietta, CA

Total Appropriation: **$13,931,934.**

Foreword

The W. K. Kellogg Foundation's mission of helping people and communities help themselves is the basis for its support of the CBPH initiative. During this past year, CBPH consortia have continued to work together to change the underlying systems that affect the public's health, through partnerships among community organizations, public health departments, and academic institutions. This report describes and reflects upon CBPH challenges and successes during this third year of implementation and offers lessons learned for the coming year.

Extensive research and common sense insights about initiatives as complex as CBPH suggest that their planning, implementation, assessment, and reformulation for long-term effectiveness takes several years to establish. It is clear that expectations for such initiatives must be tempered by an understanding of what can be produced in a short period of time, particularly when there is little history of positive trusting working relationships among those engaged. To the degree that CBPH partners have moved forward with a common vision and have shared some risks, responsibilities, resources, and rewards, they have accomplished the fundamentals of collaborative change. The significance of specific accomplishments varies across CBPH consortia and sectors; but it is important to celebrate movement of all partners who have engaged in this difficult transformation.

In the fourth and final year which lies ahead, CBPH partners will have to draw upon their cumulative experiences to distill the lessons that can take them to the next evolution of their work. The journeys CBPH partners will make to this next evolution can be thought of as passages across bridges. Some of the bridges will be relatively easy to cross; others will be quite difficult.

In part, the materials that support such bridges can be found in the evaluations that have been done at both the project and cluster levels. They can be drawn from insights gained from site visits, leadership surveys, measures of collaboration, monitoring of indicators, and cost / benefits surveys. It is hoped that this report will help CBPH partners and the Kellogg Foundation make wise decisions about what they may continue to do together, and what they may do after embarking on separate paths. The report assumes that some of the most important outcomes of CBPH will follow the bridge crossings that will take place in the coming year.

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Part 1: General Status of the Initiative

A. Introduction

In the beginning, God created the heaven and earth. And God saw everything that He made. "Behold," God said, "it is very good." And the evening and the morning were the sixth day. And on the seventh day God rested from all His work. His archangel came then unto Him asking, "God, how do you know that what you have created is 'very good?' What are your criteria? On what data do you base your judgment? Aren't you a little close to the situation to make a fair and unbiased evaluation?" God thought about these questions all that day and His rest was greatly disturbed. On the eighth day God said, "Lucifer, go to hell." Thus was evaluation born in a blaze of glory . . . a legacy under which we continue to operate."

from Halcom's
The Real Story of Paradise Lost

The above excerpt from Mike Patton's wonderful book, User-Focused Evaluation, framed the presentation made by Connie Schmitz at the 1995 Annual CBPH Meeting. It continues to provide us with the humor and humility needed now as we "package" what we've learned from evaluating the CBPH for general dissemination. So much information and reflection has occurred in these last three years that the volume of material threatens to turn this document into "the Annual Report from Hell." To deal with this volume, we've taken a team approach to the writing and presentation of results. All of the sections which follow should be seen as "executive summaries" of longer, stand-alone reports which we'll send to readers upon request. For a road map to these sections, see below.

Part I

Part I begins with a summary of Connie Schmitz's presentation (referred to above) on the status of the initiative as a whole. The views expressed here were most influenced by what we saw, heard, and learned from this year's site visits, and our impressions of how consortia stood in terms of key attributes of consortium functioning and sustainability.

Part II

Part II represents a compilation of summaries of individual evaluation components that were spearheaded by members of the Cluster Evaluation Team (CET). Reported first are

the results of two lines of inquiry not reported previously: the work of Carol McGee Johnson on leadership roles, models, and challenges in CBPH consortia (i.e., "Reflections of Leadership"); and the work of Arthur Himmelman and Michael Luxenberg on measuring ways that consortium members work together (a.k.a., the "Consortium Activities Diagnostic Survey"). Both of these components relate to the structural models being developed in CBPH, and thus to our first guiding evaluation question.

- *The Leadership Survey.* This was a qualitative telephone survey conducted in the spring of 1995 of 24 CBPH project directors, governing board chairs, and other leaders. Its purpose was to investigate the kinds of leadership models that were emerging in the CBPH, and to better understand the leadership knowledge, skills, functions, and tasks needed for multi-sector consortia to succeed. Consortia who appear to be working most successfully together have achieved a model of shared leadership which draws upon the abilities of a diverse membership and ensures collaboration.

- *The Consortium Activities Diagnostic Survey (CADS).* This instrument was developed in an effort to understand the behaviors that consortium members use when they "network," "coordinate," "cooperate," and "collaborate," and to test some assumptions about the relationships between those strategies. The instrument was piloted in the winter / spring of 1995 with members of three CBPH consortia and a Community Partnership coalition funded by the Center for Substance Abuse and Prevention (CSAP). Although the pilot was small, it was helpful for revising this tool. Measuring consortium interaction remains a difficult challenge, but an extremely important one in light of the many calls for partnership being heard across health and human service sectors.

Part II continues with two more evaluation components which relate to activities occurring within CBPH sectors, and thus address our second, third, and fourth guiding evaluation questions. The work of Cecilia Goetz on indigenous health worker (IHW) training models is new this year and has not been reported previously; the summary by Marijo Wunderlich on indicators of consortium activity and progress represents an update of work that commenced in CBPH's first year of implementation.

- *IHW Training Models.* Probably the most prominent common activity occurring across CBPH consortia at the community level is that of indigenous health worker training. In

the winter and spring of 1995, Ms. Goetz collected curriculum materials and site visited four consortia to observe some of their training sessions and to speak with consortium members and participants. What she reports in this descriptive study is a breadth of conceptualization of the health worker role which reflects the context and philosophy of the consortium in which the strategy is being used. Implications for future development and evaluation of this model are raised.

- *Indicators.* With the help of project directors and evaluators, the CET has been tracking over 50 indicators of consortium activity and progress in five categories: membership, community capacity building, institutional and organizational capacity building and change, policy, and sustainability. Data were collected retrospectively and reported for the first time in October of 1994. The second data collection period (which ended in March of 1995) resulted in notable changes in some indicator categories. It also raised new questions about the consistency and comparability of the data, and thus the wisdom of aggregating local indicators at the cluster level. In this summary, Marijo Wunderlich presents the most recent results and reviews the importance of indicator data for project and cluster purposes.

- *Costs/Benefits of CBPH.* Completing Part II is a follow-up summary of the costs and benefits of CBPH membership. In 1994, a large majority of CBPH members and leaders responded to an eight-page, mailed survey. While the results of that survey were reported last year, this follow-up analysis was conducted in the winter of 1995 to explore the factors which are most associated with satisfactory participation and with the amount of time members spend on CBPH work. While satisfaction with the CBPH seemed to depend most on personal development opportunities and the absence of internal consortium conflict, the degree of time commitment was highly associated with employment support and other material benefits derived from the grant.

Part III

In Part III, we present lessons learned for specific audiences engaged in present and future partnerships. We also outline the CET's goals and activities for Year Four.

B. Lessons From the Field: Implications of the Community-Based Approach to Improving Health
by Connie C. Schmitz

As those who have been working in CBPH consortia know, this is a big initiative with several complex goals in the areas of changing education and public health practice systems, and the orientation and capacity of communities to engage in the "business" of public health. When "outsiders" ask about the initiative, they yearn to hear the concrete specifics that typically convey the cornerstones of projects -- such as goals, objectives, and activities as they relate to outcomes. While such features can be described, the CBPH is not about projects so much as principles . . . such as community ownership, collaborative partnerships between the three sectors of academe, community, and public health practice, and the paradigms that each brings to the question of improving the public's health.

Just how are these principles put into action? How does CBPH "happen?" CBPH happens through "cultural exchanges" and new linkages between individuals, such that barriers between institutions and community are lowered, and new relationships are built. CBPH action occurs in curriculum reform, team teaching between practitioners, community people, and researchers, and enhanced student placements and field experiences. CBPH transpires also in the training of community health workers and programs which provide upward mobility for young people in the health fields.

Most centrally, the CBPH is about community capacity building and enhancing the skills, abilities, and resources that groups need to sit at the table as equal partners, and about the developmental process that all three sectors need to go through to share power and find a space where mutual concerns can become the guiding principle, rather than competition or submission of one group to another. Ultimately, the CBPH is about diversity, and the opportunity that this initiative affords to work together across our differences; to become more knowledgeable and comfortable in walking respectfully in each other's cultures; and to embrace the common principles and connections which make us uniquely American.

In short, the CBPH is not a generic program, with a known set of steps or procedures to complete or replicate, but a rather sophisticated and idealistic "world view" of how humans can re-organize ourselves to make life better for people in distressed communities. The CBPH is hard to explain because it is designed to get at the underlying systems that affect health, and we're all much more used to, and comfortable with, programs and projects with

definable inputs and outputs. Given these special qualities, what can we say as we pause for reflection here at the end of the third year? In particular, what can we say in response to our five guiding evaluation questions?

1. What kinds of collaborative, community-based public health models have consortia developed?

One way we've addressed this question is to literally diagram the organizational models that consortia have created to govern their work. Structurally, consortia have developed only two basic models. Six of the seven consortia have two levels of organization, consisting of a central consortium made up of the three sectors, and then several sub-consortia (called "coalitions," "partnerships," "pods," or project sites) that typically (but not always) also involve the three sectors. While leadership is practiced very differently in these models (see Part II, The Leadership Survey), the only other structural model was produced by one consortium, whose three sectors formed a board that then created a new organization in the community as a vehicle for addressing the goals of the CBPH. Whereas in the six dual level structures, money was disbursed among partners and coalition sites according to a percentage system, partners in the centralized model put virtually all of their money in to the newly created CBO and its staff and programming.

What are we learning about the viability of these organizational models and their relationship to philosophical or theoretical models?

- First, the models are not static. Individual members change, organizational partners sometimes change, and the governance structures in some consortia have undergone significant change due to conflict and the need to find the right "fit" between the partners, or the right degree of autonomy versus affiliation for the sub-coalitions within the consortium. The models are likely to continue to evolve as funding streams change and as partners figure out how to institutionalize the core principles and linkages established through CBPH into their organizations.

- Second, it's been tempting to assume that these structural models reflect theoretical or philosophical understandings about "small cbph" (i.e., the concept of community-based public health). If philosophy does play a role in shaping consortium structure, it is a small role. Structural models seem much more influenced by the availability of funding and the mandate that all three sectors be at the table, by each group's need for power

and control, and by the realities of geography and "natural" pairing of partners based on history, cultural affiliation, and other bonds.

- Third, the philosophical models underpinning the work of CBPH are not all the same. Considerable differences exist in what people mean when they say, "a community-based approach." Some consortia have found ways to politely agree to disagree over such things as the definition of community, desired degree of community-basedness, and even the extent of what can be called "public health." For other consortia, collaboration at the central consortium level has been quite difficult because partners view these things from different perspectives.

- Fourth, in our judgment, a minority of consortia (only three at the moment) are really functional at the consortium level in terms of collaborative governance between all partners. Consortia who are not especially functional at the consortium level, however, can be very functional at the coalition level. In consortia that are struggling at the consortium level, common problems include conflicts with governing board leadership, turnover in project directors and project evaluators, and a general difficulty with knowing how to hold partners and staff accountable. Perhaps the most serious common problem is lack of accountability: i.e., lack of clear expectations of partner organizations, lack of job descriptions that match what directors and other staff are asked to do or are actually doing, and lack of policies and procedures for what to do when perceived expectations and promises are not being met.

These lessons have important implications for groups who wish to maintain or form consortium structures.

2. <u>Has participation in the CBPH affected the communities' capacity to solve public health problems?</u>

The CET learned this year just how poorly we are situated to answer this question. Unfortunately, our ability to detect changes in community capacity is quite minimal and limited to subjective impressions gained during site visits. To address this question at the cluster level we are going to need project support and input. We need local project directors and site coordinators in the community to realize how critical their own project documentation is (e.g., their upcoming third year annual project and evaluation reports). We need consortium members to work with their evaluators to make sure that together they

document stories, examples of what is working and not working, and evidence that community people are gaining in opportunity, skills, access to resources, and even health status (when appropriate). We especially lack evidence of growing community political power, improved morale, or improved quality of neighborhood life as a result of the CBPH's community development efforts. We especially encourage members with this kind of evidence to contribute to our indicators and our upcoming video documentary.

3. Has participation in the initiative affected the capacity of member organizations to carry out their CBPH missions?

In comparison to the other two sectors, we feel that organizational change in public health agencies is either not very well defined, or simply not happening. PH practice organizations have been the least well funded of the three sectors in this initiative, and they've had the fewest members (22%, up from 19%). Their involvement has also been impacted, probably more than any other CBPH partner, by extraneous events -- notably, managed care and the enormous concurrent changes in funding, scope of mission, and reorganization. Most of what we see practice partners contributing in consortia is limited technical support or assistance to their community partners, extending their outreach in small ways, or approaching community assessment more collaboratively than before. Only two - three consortia have agencies who have taken on meaningful internal systems change.

Academic institutions have been active as support partners in this initiative, supplying primarily their community partners (and sometimes their practice partners) with technical assistance. A majority (but not all) of academic partners have also been invested in systems change, mostly through the mechanisms of course development and redesign, expanded student placements, and collaborative research based on a community approach. A few have made notable breakthroughs in changing policies related to the hiring of practice-based faculty and lay instructors, the inclusion of "outsiders" in important curriculum and search committees, and in upgrading the value of public health practice in faculty merit review, tenure and promotion proceedings.

Organizational change has been occurring at the community level as well. Over this three year period we've witnessed the emergence of some entirely new CBOs and the growing stability and capacity of existing CBOs. All the CBOs have been active in projects related to community health and well-being. CBOs in a majority of consortia have also been active in helping their institutional partners change and develop in their capacity to deliver a

CBPH mission. Some have not, however. This notion that community groups are instrumental in helping their institutional partner develop capacity has been a difficult one for some CBOs to grasp or accept. Some are not ready to partner in this way. In other consortia, the institutional partners have not known how to work with community towards this end, or been able to commit to this goal themselves. That aside, we feel this initiative has had a marked effect on many of the thirty CBOs involved in terms of leadership development, organizational and fiscal growth, stability and credibility in the community.

4. Has participation in the CBPH affected the capacity of consortium members to influence policy?

In theory, all CBPH roads should lead to policy, especially if policy is defined with a "small p" as the formal and informal "ways of doing business." As mentioned earlier, what distinguishes CBPH from "projects" is that it purports a systemic approach to change. When you get right down to it, the CBPH is all about policy, **not** individual projects. The big challenge within each consortium right now, and for the initiative as a whole, is to tap their enormous potential for collective action. If by the end of next year a consortium hasn't recognized this potential, or committed itself to developing a strategic policy plan or policy agenda, then its members may be doing very good work, but they probably don't need a consortium structure to continue doing it. Coalitions are essentially political frames or vehicles. By definition (some would argue), they work best when they are issues-oriented and short-term. Consortia on the scale of CBPH are not very efficient or effective structures for administering programs or delivering services.

During our site visits this year, we found some talk, some frustration, but not a lot of policy-related activity on the consortium level. At the coalition level, we found more political activity, a better sense of the local policies needing attention, but often this activity was ad hoc and not well recognized for its big picture value. We encourage all consortium members to stay connected to the National CBPH Policy Task Force and to explore policy areas that the three sectors might be able to address collectively.

5. For individuals and organizations involved, do the benefits of participation in the CBPH outweigh the costs?

This questions has been addressed in other reports and will discussed later in this document as well (see Part II: Cost / Benefit Survey). Suffice it to say, consortium participation has

resulted in many important benefits and many significant costs. When the Foundation brought consortia together four years ago, it knew that the marriages were essentially arranged. Now, after three years of funding, it is sane and healthy for consortia to be asking, "Is there a sound basis for a good marriage here?" "Where do we have some real mutual areas of interest? Where can we be really helpful in building each other's capacity? What linkages are working? What kind of infrastructure or support do we need to continue these linkages, or address certain policy goals?

Summary: Lessons Learned from Watching Consortia Evolve Over Time

- Creating a viable organizational model to house the efforts of multi-sector, diverse groups is a complex undertaking requiring enormous leadership skills and an immense amount of time. Not all groups get it "right" the first time around. As of this writing, three of the seven consortia had undergone complete overhauls sometime during the second and third years of implementation. Future partnerships can be better prepared to anticipate and navigate this journey.

- Viable consortia have learned how to incorporate accountability for participating partner organizations and staff. Whether accountability is formal or informal does not appear to matter, as long as it happens. Consensus decision making and a desire to collaborate may lead some members into thinking that the discomfort of holding themselves and each other accountable can be avoided. Not so. Accountability and collaboration go hand in hand. If fact, accountability makes collaboration possible -- and vice versa; the ability to hold partners accountable reflects successful collaboration.

- It's time to reflect on the consortium structure (i.e., organizational model) separately from the general principles of doing community-based public health work. Until now, many have thought of consortia and community-centered work as synonymous. As funding streams change and new political pressures and opportunities emerge, it may be useful to recognize that the principles of collaboration and community-centered work can occur through many different forms, with formal consortia being only one of them.

On the following pages, a summary of consortia status after three years is offered.

C. Status of the Initiative: A Summary Glance Across 32 Key Attributes

Attribute	Have a majority of consortia achieved this attribute to date?
Governing Board	
Functional in terms of collaboration between all partners	No
Stable leadership	YES
Has strategic plan or vision for CBPH	YES
Able to hold partners / staff accountable	No
Project Director	
Has established credibility and leadership role	No
Clear role defined by consortium	No
Evaluation	
Effective evaluator on board	YES
Stable evaluation system	No
Clear evaluation focus / role	YES
Contributing to Cluster Evaluation	YES
Model / Vision of CBPH (Consortium Level)	
Shared vision of CBPH, goals, among all partners	No
Model reflects CBPH principles*	YES
Model / Vision of CBPH (Sub-Coalition Level; n = 6)	
Reflects CBPH principles (see above*)	YES
All three CBPH sectors linked	YES
Active in implementing projects	YES

* Community capacity-building / ownership, expanded definition of "public health," goals for systems change in all 3 sectors, collaboration and linkages between sectors

Attribute	Have a majority of consortia achieved this attribute to date?
Academic Involvement - (Percent of CBPH members who are in academe: 32%)	
Engaged as support partner	YES
Initiating own systems change	YES
PH Practice Involvement - (Percent of CBPH members who are in PH practice: 22%)	
Engaged as support partner	YES
Initiating own system change	No
Community Involvement - (Percent of CBPH members who are in community: 46%)	
Has viable CBO and community base	YES
Implementing activities	YES
Active in helping partners build institutional capacity	YES
Policy Development	
Active at consortium level	No
Active at coalition level	No
Communications	
Met with Foundation consultant	No
Produced plan	No
Number of research, evaluation reports since 1992	24
Current Sustainability Outlook	
Has sustainable model on consortium level	No
Has sustainable model on coalition level	YES
Has obtained new core funding (since October, 1994)	No
Total amount of core funding gained since 1992	$438,537
Total amount of "spin-off" funding gained since 1992	$7,743,400

Part II: Lessons from Evaluation Components

A. Reflections on Leadership in Community-Based Public Health Consortia by Carol McGee Johnson

Background

In the winter / spring of 1995, a survey was conducted for the purpose of better understanding the leadership roles and challenges as CBPH groups have experienced them, and to outline a template of knowledge, skills, functions/tasks, and conditions required for successful leadership in diverse consortia.

Twenty-four leaders were selected for in-depth interviews. This number includes all of the members with designated titles of project director, governing board chair, or primary WKKF contact person. It also includes additional partners that the CET observed over the years as playing key leadership roles (e.g., fiscal agent, leader at the coalition or team level, and in one case, an evaluator). These latter individuals were selected on a case-by-case basis to provide as balanced a perspective on consortium leadership as possible. Each consortium was thus represented by a small (three to four) number of highly involved individuals.

The interviews were based on 14 open-ended questions (see the Appendix for the protocol) which were developed by the lead author and the Cluster Evaluation Coordinator, and then revised with the assistance of the Minnesota Center for Survey Research (MCSR). Student interviewers were trained and supervised by MCSR staff. Interviews ran approximately 30 - 45 minutes in length and were tape recorded and transcribed for analysis by the lead author. All interviews were granted on a voluntary basis; all information was kept confidential. All respondents received a copy of the final report in draft form for review and correction prior to dissemination.

The interviews yielded a body of information that proved rich, dense, and provocative in content. To analyze the data, remarks were clustered and then summarized by question. When possible (and as appropriate), the responses were organized by sub-group (e.g., project directors vs. other leaders; by consortia), or to show the range of response received. The main findings of the report are presented below.

Findings

The Role of the Project Director in CBPH Consortia. The majority of project directors (PDs) -- in contrast to other leaders within CBPH -- felt that their roles and

responsibilities had been poorly conceived and defined with respect to consortium mission, goals and objectives. Most PDs also felt that they had not been given the power and authority necessary to carry out their leadership responsibilities; they expressed an insecurity about their role that other leaders did not express. The high turnover rate in this position (in three consortia at the time of this report, with tensions occurring in two other consortia) is further evidence of these findings. Factors that appear to limit the success of several PDs are as follows:

- Conflictual processes within a consortium, prevalent enough to warrant process intervention.
- Lack of PD involvement during the LMD (planning and development) phase of CBPH. When PDs became involved, agendas were already set, which resulted in PDs feeling they lacked credibility, stature, and equal partnership.
- Unclear and unrealistic expectations of the role PDs should play, given organizational structures that ideally can support many leaders, but not necessarily one single leader, and resultant philosophical and operational conflicts.
- Unclear boundaries around power and authority within consortia, especially between board and staff roles.
- Lack of leadership training, development and mentoring.
- Lack of high quality skill-base in the PD position.

Factors that appear to have promoted the success of other PDs are as follows:

- Clear, early expectation and articulation of shared decision-making leadership theory and practice.
- High quality staff; good use of staff resources.
- Implementation of organizational structures that support shared, collaborative decision-making.
- Clarification and thoughtful consideration of the limitations of the PD role within a shared model of leadership.

Leadership and Organization of CBPH Consortia. The organization of CBPH consortia into both centralized and decentralized modes of operation seems to not only invite, but require, the emergence of many leaders at various points and levels within consortia, both formally and informally. Again, the challenge of organizing leadership into a shared model across constituencies, organizations, geographic locations, and diverse

cultures is the major challenge facing CBPH consortia. Such organization takes into account the building of a collaborative, shared mission and goals among partners, so that leadership emanates from the whole, rather than any single part or individual. As one leader put it, "the challenge is to figure out how all the entities, powerful leaders, and achievers can work together." Factors that appear to limit the success of some leaders within CBPH consortia, with respect to consortium organization:

- Lack of effective bridges between consortia and constituent groups; unwieldy consortium structures.
- Lack of sufficient communication between the various parts and entities of consortium structures; the difficulty of the collaborative process.
- Lack of time to carry out the myriad activities associated with collaborative work.
- Lack of knowledge about shared, collaborative leadership processes.
- Inconsistent, insufficient representation of all the partners at various activity centers in consortia, or not enough centers of activity where cross-representation can take place.
- Notions that there is "one way" to do CBPH work, i.e., the model of one project director, or "a pure CBPH model."

Factors that appear to promote the success of leaders within CBPH consortia, with respect to consortium organization, are directly related to the factors that limit success, as follows:

- Frequent, effective, consistent communications, formally and informally, "behind the scenes," of consortium operation.
- Theoretical and practical understandings about shared leadership and the collaborative process; shared vision; clear delineation of roles and responsibilities.
- Commitment of time to meet, get to know one another, build trust and relationships, and carry out CBPH work.
- Setting limitations on the number and kinds of projects that can be taken on and carried out effectively.
- Cross-representation of partners throughout consortium structure and across activities.
- Flexibility with regard to various models of and ways CBPH work can be carried out.

Leadership Competencies and Who Brings Them To CBPH Consortia. Survey data indicate that an enormous breadth of leadership knowledge, skills and functional ability is required for successful consortium management and operation. Certainly far more competencies are required than any single leader might bring. The data

also suggest that the competencies needed are brought unevenly to consortia, in that academic and health practice partners were cited more often than community partners or project staff as bringing those skills, along with a general impression that the frequency with which competencies are brought to consortia is insufficient for optimum consortium operation. The factors that seem to limit the success of broader application of leadership competencies within consortia are as follows:

- Poor development of staff and/or poor choice of skilled staff.
- Insufficient training and development opportunities of core competencies and organizational skills, and for skill transfer, especially among community partners and project staff, to effectively support the notion of shared leadership.
- Limited vision of the breadth of competencies needed for successful, shared leadership.

Factors that seem to promote the success of broader application of leadership competencies within consortia, are as follows:

- Many opportunities for skills transfer, so that leadership can be truly shared between institutions and communities.
- Training opportunities that reflect knowledge of the breadth of competencies needed for successful leadership.
- History, knowledge, and experience working in community.

It is important to note that the data suggest that respondents felt that the *knowledge* (in contrast to skills, functions, or tasks) needed for successful leadership was brought equally by academic, health practice *and* community partners. It is also important to note that PDs were rarely named as bringing essential knowledge, skill, or functional ability to consortia.

The Role of Evaluation. Effective use of evaluation data, both at the project and the Cluster Evaluation levels, was pointed out as a factor that promotes success in CBPH consortia, in the following ways:

- As a means of capturing the increasing capacity of consortium members to work in partnership with various sectors and institutions within the community.
- Increasing the critical ability of leaders to "keep their finger on the pulse" of consortium development, and anticipate problems early.

- Identification of multiple strategies and approaches to CBPH work, as well as identification of lessons learned across consortia, especially in consortia that are struggling to achieve their goals.

Summary: Lessons Learned

1. The role of project director needs to be redefined to more closely match the spirit, intent and organization of CBPH consortia. Redefinition of this position might include consideration of titles such as "project coordinator," "project liaison," "project facilitator," etc.

2. Models of shared leadership that are consistent with CBPH vision, mission, goals and objectives need to be clearly articulated and made fully operational, and consortia must be held accountable to shared leadership practices. The notion that consortia are most effectively led by a "team of qualified individuals" might be considered as a way of reducing unrealistic expectations and notions of leadership that are dependent on a single individual.

3. Extensive leadership training needs to be integrated into consortium operation, with an eye to building equal foundations of knowledge, skill, and functional ability among *all* partners. Such training is critical to the consistent achievement of shared leadership. It is also critical in addressing the current prevailing notion in a significant number of CBPH consortia that leadership competency is brought by only a few individuals, and in some cases not at all. Such training must effectively include opportunities to build group facilitation, collaborative process, communication, project implementation, and staff management skills, and to involve all stakeholders from the beginning.

4. Effective use of evaluation by leaders in CBPH consortia should be a requirement of leadership. The critical role that evaluation plays in helping leaders assess progress, hold consortium members accountable, refocus work and consortium direction cannot be overstated.

B. Consortium Activities Diagnostic Survey (CADS) by Arthur Himmelman and Michael Luxenberg

Background

This year, members of the CET worked to develop a tool called the Consortium Activities Diagnostic Survey (CADS), the purposes of which were to: (1) better understand the behaviors that consortium partners use when they work together; and (2) to help consortia (and various groups within them) assess the degree to which they are using a particular strategy for working together. CADS is perhaps most useful when applied in a "self diagnosis" manner by partners to determine whether they want to enrich a particular strategy or expand their repertoire of strategies.

The four strategies explored were: networking, coordinating, cooperation, and collaborating. The CADS does not imply that any one of these strategies is inherently better, or the most appropriate for any given activity. Nor does it suggest that the strategy of collaboration, for example, is best because it is the most complex. Rather, CADS suggests that each strategy can be appropriate for given circumstances depending on (among other variables) levels of trust, degree of shared values, and the strength of common commitments.

Pilot Process and Results

While the four strategies have straightforward appeal and heuristic power, they have not been previously operationalized or developed as a measurement tool. Thus, this year provided an opportunity for item development, pilot testing, analysis of pilot data, and revision. The primary purpose of the pilot was to test the degree to which these four strategies could be measured reliably by specific behaviors people use in groups (e.g., "share information about job opportunities;" "alter plans so that a combined event could be held;" "share funding resources;" "enhance each other's capacity by helping each other develop training or curriculum materials"). The secondary purpose was to explore the relationship between the four strategies, and the degree to which they reflect discrete ways of working together within a developmental continuum. In order to explore its generic utility, and to increase the size of the pilot sample, CADS was piloted with members from three CBPH consortia and one Center for Substance Abuse and Prevention coalition in Minnesota. The results of this pilot can be read in detail by requesting a copy of the technical report.

Based on preliminary results and a smaller sample than anticipated (N = 39), we found that CBPH and C-SAP members were very much alike in their responses. Each group appeared to be engaged in about half of the behaviors listed for each of the four strategies. Additionally, most of the behaviors listed were reportedly being used some, but not all of the time. Reliability estimates obtained for the total group were quite high for each scale (Cronbach alphas = .96, .97, .99, .96). This was encouraging, in that it suggests that the behaviors we used to illustrate networking, cooperating (etc.) were internally consistent. A surprising finding was the high overlap between the four scales in terms of intercorrelations of items. This suggests that when people work together they draw upon all four strategies simultaneously and equally, rather than emphasize one strategy predominantly or to the exclusion of another. Whether this means the four strategies are truly less distinct, or more interdependent than expected, or whether this is just an aberrant reflection of this particular pilot sample, is not known and requires more investigation.

Implications and Next Steps

Originally, we had hoped to gather data from at least 100 respondents, in order to perform factor analysis and other statistical operations that would have more thoroughly explored the reliability and validity of the instrument. Because of the small sample size, any conclusions we might make (positive or negative) are really premature. Open feedback was solicited from respondents, however, and this is being used to help us improve the quality of the items, instructions, and the survey's general format. Most of the feedback we received was positive. People felt that the survey assessed their modes of interaction reasonably well, the survey challenged them to think more critically about what it really means to "collaborate," and gave them new ideas about ways to put the four strategies into action.

Ultimately, CADS may be most helpful as a heuristic device or a learning tool, rather than a diagnostic/evaluation instrument. Ideally, CADS could prove most beneficial to groups if it were offered to partners at various levels within a consortium, and repeated at various times throughout the life of a program. The specific behaviors listed in CADS may be thought of as possible guides to action. For example, if a consortium has not done the things listed under cooperation (e.g., "joint use of speakers, trainers, and consultants"), it may choose to do so as part of its implementation plan. Because there are relatively few existing measures of collaboration, CADS is by nature highly experimental. We offer it to any CBPH members who desire to use it (see Appendix). Please send your requests for surveys, user manuals, and copies of any test results and feedback to: Dr. Michael Luxenberg, Professional Data Analysts, 219 S.E. Main Street (Suite 504), Minneapolis, MN. 55414.

C. Indigenous Health Workers in the CBPH
by Cecilia Goetz

Background

The indigenous health worker (IHW) model, used extensively in the developing world and popular in the United States during the 1960's and 1970's, is experiencing a resurgence of interest as the current health system struggles to address health issues with complicated social etiologies. As seen in a literature review of this topic, IHW roles can vary significantly. Usually, the term is applied to acknowledged leaders in a community (i.e., people sought out by friends and neighbors for help and advice) who receive special health-related training to further serve their community. IHWs may "function as a health educator, advocate, or community organizer, in addition to making referrals, or performing screening and other clinical services. They may or may not be paid...what characterizes and distinguishes these individuals is that they are from the target community and have been recognized as natural leaders" (Cluster Evaluation Indicator Documentation Forms, 1994). IHWs are often thought of as a link between the formal health system and the community; they can also foster or reinforce existing community networks.

The IHW model has emerged as a strategy across CBPH consortia for both increasing community capacity and well-being, and for linking the three consortium partners together as they design and implement IHW training. The IHW model is currently being implemented in at least four CBPH consortia: North Carolina (in both Wake and Lee Counties), Michigan (in both Detroit and Genesee County), Maryland, and California. Because IHWs emerged as a central CBPH strategy, the CET decided to devote additional time in this third year to understanding their roles, training, and general context. Two guiding questions framed this descriptive study:

- *How does the IHW model vary across consortium sites?*
- *What factors appear to influence the development and implementation of IHW models?*

Method

Selection of Sites. Six sites representing four CBPH consortia were included in this study. Sites were identified in the summer of 1994 on the basis of information gained by the CET during their second-year visits. At that time, four consortia had initiated active training

programs for IHWs as an integral part of their overall consortium strategy. During the course of the study, several additional health worker initiatives were brought to our attention; specifically, efforts in two Massachusetts coalitions, and additional efforts in Michigan. Time and resource constraints however, limited this study to the identified sites in North Carolina, Michigan, Maryland, and California.

Data Collection Strategies. In order to understand the similarities and differences between the six IHW models, four strategies were used: document review, two-day visits to each program site, observation of IHW training sessions, and interviews with key individuals (e.g., participants, trainers, and program sponsors). To organize the inquiry and the presentation of findings, six topical areas were identified:

- Description of the community context, target population being served
- Goals of the IHW program
- Processes used to recruit IHWs; eligibility criteria used in selection or recruitment
- IHW roles, responsibilities, employment status and other financial incentives
- Content and structure of the training curriculum
- Post-training activity: ongoing support, supervision, education, and evaluation

Findings

At the time of this study, 121 individuals had been trained by these IHW initiatives; approximately 90 of these were still active in the community. While all of the IHW models visited share a commitment to building community capacity and well-being, they vary significantly in how they define the term "IHW" and interpret the role (see chart following page 25). Differences in the format and length of training (from 12 hours in North Carolina, to over 160 in Maryland and California), and differences in health workers' background and experience, employment status, degree of autonomy after training, and role in the community illustrate some of the dimensions on which IHW models vary. A spectrum emerged which ranges from:

(a) an emphasis on enhancing volunteer lay helper activity through training in leadership, advocacy, and community organizing (e.g. Michigan and North Carolina); to
(b) a focus on training community people in screening and outreach, in order to offer disease prevention and health promotion services at neighborhood-based sites (e.g. Maryland); to

(c) a concentration on job training and employability for residents seeking paid work at existing community health clinics or the public health department (e.g. California).

IHW models appear to be influenced by several related factors:

- The context which surrounds the IHW project (i.e., the social, political, cultural, and economic characteristics of the community);
- The broader "world view" or vision which guides the CBPH consortium; and
- The goals of the IHW project: what the project wants to accomplish and how.

Thus, in Maryland (for example), the dynamics of the East Baltimore community, and especially the partnership between two historically powerful institutions (the church and Johns Hopkins University) shaped their IHW model. Guided by the pastors of the African American churches and individuals from the Johns Hopkins University Center for Health Promotion, the Maryland vision combines principles of community ownership with chronic disease management and prevention to generate an IHW training curriculum that focuses on medical content, certification in technical procedures, and referral protocols. Diseases prevalent in the East Baltimore community have been targeted and improvement in health status indicators is the ultimate goal.

In Detroit (for example), the context of an urban setting with a multitude of CBOs, a strong police precinct system, an established church with a large, African American congregation, and an orientation to neighborhood development is reflected by a vision similar to David Werner's concept of village health workers.* A world view which believes in identifying and supporting existing community leaders and neighborhood activism led to a training focus on community organization and advocacy skills. IHWs are not trained to fit pre-defined employment slots, so much as strengthened to serve as change agents in community development.

In California (for example), the IHW model reflects an extremely diverse community, with a multiplicity of ethnically-based community clinics and other organizations. Awareness of training and employment needs shaped their IHW model, which concentrates on building individual and community capacity by developing job skills of previously unemployed or at-risk residents, and facilitating their entrée into the health outreach pipeline. Their target population necessitated significant emphasis in the curriculum on multicultural skills.

* See Werner, D. and B. Bower, Helping Health Workers Learn. Hesperian Foundation, Palo Alto, CA 1995.

Implications

- Lack of precision in the term, "indigenous health worker," will likely cause future researchers difficulty if they try to evaluate the efficacy of models across sites. As seen in the CBPH, definition of an IHW varied from the Cluster Evaluation definition, and was often loose and dissimilar from site to site. An IHW in Maryland, for example, is typically paid to do health screening and outreach in the community; while they are committed to the community, IHWs are not required to be long-term residents of East Baltimore. In California, training focuses on enhancing employability of persons who have not necessarily been previously recognized as "natural" leaders in their community. Michigan and North Carolina models come closest to the more traditional use of the term, as we understand it, in empowering "natural leaders." Each of the models studied could presumably lead to different expected outcomes. Thus, future research and evaluation will need to differentiate among them.

- On a consortium level, IHW models have the potential to link consortium partners in important ways. In Maryland, for example, IHW training unites partners from three schools at Johns Hopkins University, Clergy United for Renewal of East Baltimore (Heart, Body, and Soul), and the Baltimore City Health Department. Similarly, in Michigan, the health departments in both Detroit and Genesee County work with their respective CBOs, churches, and faculty and students at the University of Michigan Schools of Public Health and Social Work, to develop and implement IHW training. The extent to which collaboration can or should occur between partners in IHW models may be a useful question for groups using this strategy to address.

- On a community level, an IHW model can strengthen existing community networks and relationships. In California, for example, the Community Health Academy works actively through CBOs in the Crossroads community to recruit and place trainees. In Maryland and Michigan, connections are made with other community organizations to provide IHWs with opportunities for certification training in specialized areas. The extent to which an IHW model builds linkages between community resources may be another question for groups using this strategy to address.

- On an individual level, the IHW model can be a powerful experience for participants. Community people who engaged in the IHW models described here spoke about the personal benefits they received, such as increased skills, support for their community

work, new job or employment opportunities, and a sense of fulfillment of "giving back" something to the community, or of helping others by sharing their own experiences. More follow-up can be done, however, to clarify what level of activity constitutes a "practicing" or "active" IHW, as well as the amount of ongoing support and training they need or desire to remain active, and the reasons why some IHWs choose to discontinue their participation.

Conclusion

IHW models are emerging as an integral strategy for working toward community empowerment and health, and a central component of much of the work of the CBPH. As the context surrounding health becomes increasingly complex and the search for alternative paradigms continues, the IHW model provides strong potential and opportunity for enhancing community resilience and fostering capacity within individuals and communities. Critical areas relative to IHW models which emerged during this study relate to the need for more precise and standard use of terminology and concepts, and the related need for further evaluation on the impact of IHW models.

HW Models in Four CBPH Consortia

	California	*Maryland*	*Michigan: Detroit*	*Michigan: Genesee*	*North Carolina: Wake*	*North Carolina: Lee*
Terminology	Community Health Worker (CHW)	Neighborhood Health Worker (NHW)	Village Health Worker (VHW)	Church Health Teams/Members	Community Health Advocate (CHA)	Natural Helper
Average Age	30 years	40 years	43 years	Mid 50's	40 years	42 years
Experience as Natural Leader	Not common to CHWs	Varies, but overall not common to all NHWs	Highly desirable majority of VHWs engaged in community	Majority of Church Health Team Members active natural leaders	Majority of CHAs are active natural leaders	Current Natural Helpers all active leaders
Reimbursement	Stipend of $450 provided after training; CHWs seek jobs after training	No stipend during training. Some NHWs are paid; some are volunteers	No stipend during training. All VHWs are volunteers.	No stipend during training. All Church Health Workers are volunteers.	No stipend during training. All CHAs are volunteer.	Stipend of $50.00 after training. All Natural Helpers are volunteers.
Length of Training	7 week training totaling 162.5 hours of which 41 hours is work experience	Basic training is 29 sessions and spans a nine-month period. 162 hours total. Additional certification training available in specific areas	*Basic*: 16 hours *Inservice*: bi-weekly, 1.5 hrs./varies *Peer-Peer*: monthly, 3 hours *Certification Training*: varies	8 sessions of 3 hours each Total of 24 hours for basic training	10 sessions of two hours each: *Leadership:* 8 hours *Health Track:* 12 hours Total: 20 hours	10 sessions of two hours each. Flexible: either once or twice a week. Total: 20 hours
Content of Training Curriculum	Skill provision: Job training/ employability, community health issues	Skill provision: Competency focused training with emphasis on technical skills/ screening procedures	Emphasizes advocacy/ skill enhancement; community organizing; accessing health system	Tailored to needs/ interests of trainees; emphasizes advocacy/ skill enhancement; community health issues	Emphasis on leadership and community development; health tracks incorporate skill enhancement	Tailored to community-identified issues; emphasis on advocacy/ skill enhancement

IHW Models in Four CBPH Consortia

	California	*Maryland*	*Michigan: Detroit*	*Michigan: Genesee*	*North Carolina: Wake*	*North Carolina: Lee*
IHW Role Post Training	Ultimately, employment for trainees in community health field in the Crossroads community	Through neighborhood centers, NHWs conduct health screening/ referral/ follow up in community	VHWs encouraged to identify issues in community and develop approach	Activity determined by individual health teams and is based on needs of the community	Activity determined by individual CHA and based on needs of community	Activity determined by individual Natural Helper and based on needs of community
Post Training Support	Three month job placement service through Community Resource Development Corporation	Certification training opportunities offered when available; weekly/monthly staff meetings	Regular monthly meetings with Community Health Coordinator; certification training when available; VHW activity tracked by contact sheets	Regular monthly meetings; additional in-service training offered as available; health team activity tracked using contact sheets	Regular contact with Director of Training; CHA activity tracked using contact sheets; additional training offered when available	Monthly in-service meetings with training coordinator; Natural Helper activity tracked using contact sheets;
Sponsoring Agency	Community Health Academy (a community-based organization founded by the CBPH consortium)	Heart, Body, and Soul (community partner) and Johns Hopkins University	Detroit Health Department; Hartford Agape House (community partner); University of Michigan	Flint and vicinity Action Community Economic Development corporation (community partner); Genesee County Health Dept.; School of Public Health	Southeast Raleigh Center for Community Health and Development (community-based center founded by Wake Coalition); Wake County Health Dept.	Lee County Health Dept.; UNC School of Public Health
Certification	No formal pathways currently exist	Certification pathways in areas such as: Diabetes, TB, CPR, Vision, Substance Abuse, and HIV	Certification pathways in areas such as: HIV/AIDS, CPR, Substance Abuse	No formal pathways currently exist	No formal pathways currently exist	No formal pathways currently exist

D. Indicators of Consortium Activity and Progress
by Marijo Wunderlich

Background

Two rounds of indicator data collection have occurred to date. The first, which was accomplished in the fall of 1994, represented consortia activity which had occurred in the first two years of the CBPH (September, 1992 - October, 1994). The second was completed in March, 1995, and represented the first follow up interval; data will continue to be collected every six months until the initiative terminates. The process for submitting and checking data was similar for each collection effort. After the indicator data were submitted by consortia, the CET made individual telephone calls to each contact person (usually the project evaluator). The completed indicator forms were then reviewed and any confusion, double entries, or unclear data were discussed. This helped us to gauge the extent of reliability and validity of the data and the processes used by individual evaluators to obtain their information, as well as the comparability of data across consortia. After the individual data charts were assembled, the data were aggregated by category for all CBPH consortia.

Current Results

To review the current level of activity and numbers of participants involved in CBPH, please see the Appendix for a set of tables and narrative description of each indicator category. As this information suggests, a lot of activity has occurred in the CBPH since 1992. In the community-capacity building category, consortia continue to build on their efforts to support youth, to create a cadre of community health workers, to implement health education and promotion activities on a community level, and to develop communities or augment their efforts to mobilize around health issues. What the numbers in these categories tell us is that effort is being made; to know much more about the quality of those efforts, and the impact on individuals, intense local evaluation would have to take place. One area that seems especially important for current or future partnerships to explore is the relationship between some of the more clearly developed youth activities and associated health status indicators. Another area warranting further evaluation is the discrepancy between trained and practicing indigenous health workers. Less than 50% of all IHWs trained across consortia are believed to have continued their activity after training.

In the organizational capacity-building category, continued efforts are being made to strengthen the personal and professional skills needed by all partners to work in multi-sector consortia. Perhaps

the most common topic or skill area addressed in the many different seminars, retreats, and training workshops reported is that of cultural diversity. Other common topics concern community approaches to public health practice, teaching, or research. In terms of the "cultural exchanges" being reported, more of these one-on-one exchanges involve community and university partners, than either of these partners with the public health practice partner.

Other notable organizational changes have been reported by academic, public health practice, and community organizations, as well. The strongest increases can be seen in the number of courses developed or revised and the number of students being affected by CBPH. It is noteworthy that more courses are revised (rather than developed from scratch), and the primary type of course change being introduced concerns the incorporation of community principles, perspectives, or community development skills. It would be interesting to explore the extent to which all of these courses share objectives related to the public health competencies articulated first by the Public Health Agency Forum, and later elaborated by the Maryland consortium. What is also interesting to note in the list of course titles reported is the apparent lack of courses focusing on leadership skills or organizational change strategies for better preparing organizations for community-centered work (see table on p. 29). This seems a critical education area for sustaining CBPH.

In terms of sustainability and policy development, consortia continue to have more success in generating *spin-off* grants (benefiting one partner for related CBPH work), than *core* grants (to support the consortium as an on-going entity). The policy area had made some, but not a lot of progress since the first reporting period. Across all consortia, only 16 policy influentials had been brought to various CBPH tables to strengthen a consortium's policy agenda. This would appear to be an insufficient number, if the initiative is intended to evolve into a "movement." Perhaps this figure has improved over the last six months with the establishment of the national CBPH Policy Task Force.

Strengths and Limitations of the Indicator Data and Collection Process

From reviewing the indicator forms and talking with project evaluators, it is clear that data management practices still vary significantly across consortia. Some data collection contact persons are much "closer" than others to the type of information needed for the indicators. Some have clear sources to turn to for information (e.g., hard documents or other people); others have greater difficulty getting information from or about the many components that comprise the consortium. There was also variability in the perceived effort put forth by contact persons and other consortia members, and the resulting clarity and completeness in what was reported. In

several consortia, the data were exceptionally clean and substantive, and other consortia had made significant improvement in data quality since the previous collection period. Challenges for individual consortium indicator systems include the following:

- Lack of ongoing monitoring systems and strategies necessary to generate more valid and reliable data bases.
- Contact persons' difficulties in accessing information due to political barriers and lack of communication; absence of authority and support to have systems in place, or to receive the information when requested.
- Difficulty of quantifying concepts that are abstract and not easily measured.
- Difficulty of assigning change to CBPH, when multiple projects and funders have contributed to efforts.

The challenge of aggregating individual consortium data at the cluster level is mainly that of standardizing activities and efforts, given the diversity of consortia goals and processes. As Ms. Goetz's profile of indigenous health workers show, even when we think we're counting the same thing (i.e., IHWs), very different persons with different training, expectations, and roles are being lumped together.

Despite these challenges, the CET feels the process of collecting the data and discussing what the data mean have been very illuminating. The indicator information gives us a very good idea of the approximation of effort of consortia in a range of activities. It has helped us to develop a common language in talking about these areas, and in being clearer about what the CBPH involves. The information is also helpful in site visits, as it prepares us to look at the areas of effort which have been reported. Additionally, comments from project evaluators indicate that, despite the work involved, most project evaluators value the process for what can be incorporated into their own evaluations. And, it stimulates more conscious monitoring and documentation on the part of consortia members in how they are expending their energies in CBPH.

Content of University Courses that were Developed or Revised for CBPH

The following numbers were taken from the Indicators Documentation Forms and reflect the number of courses developed or revised for CBPH since the first year of implementation (fall, 1992). Course content was inferred from course title alone.

New Courses Developed

Number	Content
n = 16	Significant community content that appears to support a CBPH philosophy, e.g.: • health advocacy • community-based public health • diversity and cultural competence • community health • special topics in community health, e.g. violence, homelessness • community assessment • health in disadvantaged populations
n = 4	More standard public health curriculum focus, but presumably influenced by CBPH, e.g.: • occupational health • women's health • health policy
n = 4	Emphasis on practice or the practitioner, e.g.: • public health practice • health officers: public health problems • introduction to health careers
n = 2	Independent studies in the community

TOTAL: 26 new courses, as of March, 1995.

continued

Revised Courses

Number	Content
n = 20	Standard public health content, with some community / CBPH theme added, e.g.: • nutrition • epidemiology • health education / health behavior • international health • health planning or policy
n = 11	Primary community content, with further influence by CBPH, e.g.: • community organizing • community development • community outreach • community health • community-based health programs • race and health • canoe building and paddle making • community needs assessment • communities, families, and health
n = 6	Analytic or methods courses, changed to incorporate CBPH principles, e.g.; • research or evaluation methods • problem solving in public health • qualitative methodology
n = 4	Emphasis on the practitioner, e.g., public health practice, or public health practice at the local level.
n = 2	Primary orientation of content could not be inferred from course title

TOTAL: 43 courses revised, as of March, 1995

Summary

A review of both developed and revised courses (n = 69) by title suggests that the largest category (39%) comprises courses with primarily a community orientation. The next largest category (35%) comprises courses that may be considered more standard to the public health curriculum, but developed or revised to reflect CBPH principles. The third largest category (19%) comprises courses that focus on public health practice, as influenced by CBPH. Notably missing are courses focusing on leadership skills or organizational change strategies.

E. Follow-Up Study on the Cost / Benefit Survey by Connie Schmitz

Background

To better understand the costs and benefits (broadly defined) of belonging to a CBPH consortium, the CET surveyed individual members, and the leaders of their organizations, in parallel questionnaires in the spring of 1994. The purposes of the individual member survey were to:

- Determine whether members feel the benefits of belonging to a consortium outweigh the costs.
- Compare the costs and benefits across academe, public health practice, and community.
- Compare the costs and benefits across consortia.
- Explore which factors influence a positive cost/benefit assessment and high participation rates of members.

It is important to study the costs and benefits of membership for several reasons. First, the overall assessment of whether benefits exceed costs is a rough indicator of morale and the general status of the initiative. Both common sense and prior research indicate that people are not likely to stay connected to a group if the costs exceed the benefits. Thus, a positive cost/benefit assessment is an important indicator of consortium longevity. Second, if project leaders and funders can learn what reinforces members, and what discourages or constrains their involvement, they can apply this knowledge to the design and management of collaborative efforts. The summary below highlights lessons learned with regard to the factors that influence members' overall cost/benefit assessments, and the degree of time commitment they make to the CBPH.

Findings: Factors Influencing Overall Cost/Benefit Assessments

To better understand which factors might predict an overall positive cost/benefit assessment, follow-up analyses on the original survey data were done in winter of 1995. To measure the overall cost/benefit assessment, we used an item that asked, "Overall, how would you rate the benefits of belonging to your CBPH consortium?" The response options available formed a five-point scale, with "Many more benefits than costs" as high and "Many more costs than benefits" as low. After factor analyzing all the survey items, eight potential predictor factors were identified (see next page):

1. **Personal Development**
   (e.g., networking opportunities, support from leaders, new friendships, positive recognition, leadership opportunities, new knowledge)

2. **Internal Conflict**
   (e.g., with other CBPH members over goals, resources; negative collaboration)

3. **Goal Attainment Activities**
   (e.g., the member activity level in meaningful CBPH goals, such as addressing health policy, assessing community capacity, recruiting people of color, delivering health services, providing opportunities for youth)

4. **Employment Support**
   (e.g., salary, new job, higher pay, job promotion)

5. **Mid-Project Assessment**
   (i.e., perceptions about whether the consortium has clear goals, needs restructuring, is headed in the right direction, or is the right model for working on public health problems)

6. **Material Support**
   (e.g., new or improved work space, equipment, release time, staff)

7. **External Conflict**
   (i.e., with non-CBPH people, such as other staff or faculty, bosses, chairpersons, family members, non-CBPH groups or organizations)

8. **Exclusion**
   (e.g., excluded from policy arenas due to CBPH participation, or isolated due to personal conflict with CBPH)

The analysis revealed a high multiple regression coefficient (R = .71) for a model which selected seven of the eight predictor factors. The factor which accounted for the greatest proportion of the variance was personal development, followed by low internal conflict and positive mid-project assessment. Together, these three factors accounted for nearly 40% of the variation seen in members' overall cost/benefit ratios. For community members, the best predictor of a positive cost/benefit ratio was low internal conflict, followed by positive mid-project assessment and goal attainment. For public health practice members, the best predictor was personal development, followed by goal attainment. For academic members, the best predictor was personal development followed by positive mid-project assessment, and then by low internal conflict.

Findings: Factors Influencing Degree of Participation

To better understand which factors might predict *participation*, the same eight predictor factors were used in follow-up analyses. "Degree of participation" was measured by a composite of items which asked members about the amount of time they spend on the CBPH (e.g., hours per week;

percent of time in the last month, in the last three months, and in the last year; number of meetings per month; perception of time demands of the CBPH).

The analysis revealed an even higher multiple regression coefficient (R = .80) for participation than for overall cost/benefit assessment. The prediction model for participation selected four of the eight predictor factors. The factor which accounted for the greatest proportion of variance in participation level was employment support, followed by personal development and material support. Together, these three factors explain almost 60% of the variation in participation -- a significant amount. For community members, the best predictor of degree of participation was employment support followed by low internal conflict and material support. For public health practice members, the best predictor was employment support followed by material support and a positive mid-project assessment. For academic members, the best predictor was employment support followed by personal development.

Summary: Lessons Learned From the Follow-Up Study

The survey will be repeated in Year 4 of the CBPH. At that time, we will learn more about how the costs and benefits of consortium membership change over time. To date, however, the follow-up study tells us that:

- Community people are generally feeling the most positive of the three groups, but their assessment of the costs/benefits are affected by the perceived amount of internal conflict in the consortium.

- Academic and public health practice members are comparatively less positive about the initiative than community members, but still positive overall. Their assessments of CBPH involvement depend especially upon the opportunities for, or perceptions of personal growth and development.

- Some consortia are more at-risk than others, given the amount of internal conflict reported.

- The factors that influence members' positive cost/benefit assessments are not the same factors that influence high participation. Whereas personal development was the best predictor for positive cost/benefit assessments, employment support was the best predictor for participation for all three sectors. When we investigated further, we learned that cost/benefit assessments (while statistically significant) were minimally correlated with participation levels (r = .15,

$p = .032$). This is rather startling -- and at first, counter-intuitive. This means that it's possible for members to be working in the CBPH even though they feel the costs exceed the benefits; and conversely, it's possible for members to spend little time on the CBPH, even though they value it highly.

What we have learned from this survey, in fact, is that participation depends -- at least in part -- upon resources, primarily in the form of employment support, but also other kinds of material benefits. This is unexpected, in that the amount of money available to members is generally small, and only one-third of the members get salary support. It is also surprising, given that the research on costs and benefits has tended to find low predictive ability of material factors in voluntary associations. The key word here, however, is "voluntary associations." Most of the research on costs and benefits has been conducted with citizen groups (i.e., block clubs, crime watch task forces, advocacy groups) who have virtually no resources to share; or with trade associations (or other societies or clubs) where dues are minimal and returns are mostly in-kind. Membership is almost exclusively unpaid.

In contrast, the CBPH is a partnership that depends upon outside resources for existence. Employed professionals in academe, public health agencies, and community-based organizations can not spend time on the CBPH without organizational sanction, and that sanction comes with resource support. While money is not the prime motivator (it does not predict members' sense that the benefits exceed the costs), it appears to function as a prime enabler; it *allows* participation to occur. These results suggest that W. K. Kellogg dollars have been critical in sustaining these consortia, and that outside funding will continue to be essential for consortia to survive.

Part 3: Cluster Evaluation Summary and Transition

A. Lessons Learned: Reflections on Year Three for Specific Audiences by the Cluster Evaluation Team

Throughout this report we have tried to draw out the important findings and lessons learned from our various evaluation components. In so doing, we have summarized findings for consortia members and other general audiences. In this final section, we synthesize our thoughts across evaluation strategies and speak individually to specific audiences, namely: public health agencies, academic institutions, community-based organizations and citizens, mixed groups engaged in partnerships, and potential funders.

Public Health Agencies

As reported earlier, experiences with the CBPH have been variable. Some public health agencies engaged more fully with the initiative than others. Public health agencies that engaged successfully in the CBPH -- both as support partners and agents of their own institutional change -- appeared to have several strategic features in place. For example:

- They had proactive leaders who had been reading the literature, attending conferences, networking with other professionals, and operating generally at the forefront of innovative change.

- In some cases, these agencies had a history of involvement with highly experienced community partners, who had the patience and wisdom to assist their partners with improving the agency's relationship with the community. In other cases, agencies had key staff who spent significant time in the first year getting to know various community-based organizations and their leaders, scouting the territory and checking the political lay of the land, before issuing formal invitations of involvement.

- They had leaders and staff who were sensitive to, if not already experienced in, a capacity building, assets-based approach. They consciously developed all of their strategies within that philosophy, so as to not subconsciously replicate a service mentality cloaked in collaboration rhetoric.

For the agencies who were already primed in a CBPH direction, the small financial incentives, the stimulation of interacting with consortium partners, and the opportunities created by being part of the national CBPH created a momentum that built as years passed.

One question we're left with is whether public health agencies need a compatibility of scale with their targeted CBPH neighborhood in order for the approach to be successful. That is, for an agency to justify the up-front investment of time and staff that a community capacity building, collaborative approach requires, several things may need to be in place. The agency (or department within an agency) may have to be small enough to be able to make the organizational changes and assignments necessary. The targeted community may also have to be small enough, sufficiently defined and cohesive to present a unified presence at the table. Significantly, the community needs to be within the agency's jurisdiction and represent an important constituency. Conversely, agencies who are (a) distant from their community sites, or (b) part of larger bureaucracies serving many diverse constituencies, may find it difficult to conceptualize relationships with "the community." With so many potential micro communities within their jurisdiction to choose from, the question becomes, why this one? How can CBPH be used as a demonstration project? How replicable is small-scale CBPH? Collaboration between agencies and communities may thus be easiest when a compatible match in scale and associated features are present.

Agencies who became successfully engaged in the initiative report that taking a community centered, assets-based, collaborative approach was beneficial in tangible ways. CBPH brought them in touch with the community in a way they had not been before. This not only meant that new avenues for reaching hard-to-reach populations opened up, but that department staff were able to design, implement, and assess prevention and education strategies with much greater confidence and clarity. By taking a facilitative rather than a directive role, they saw community ownership could occur, and a transformation in community morale could take place. By sharing health goals and problems, the load of the public health agency could actually be lightened. In some cases, it meant that the community (along with other consortium partners) became powerful allies in the political arena, helping the agency to actually increase its budget and achieve desired policy goals.

Unfortunately, CBPH presented a challenge for some agencies, who remained underinvolved well into the third year of the initiative. Underinvolvement of these agencies seemed to reflect one or more of the following factors:

- Lack of visionary leadership at the top.
- Insufficient number of core staff interested, committed, or assigned to this effort.
- Lack of designated funds from either the CBPH or internal budgets.
- Lack of community development knowledge or skill.

- Lack of history of involvement at the community level.
- A perception that political and fiscal constraints precluded innovative thinking.
- Lack of understanding about and preparation for being agents of their own. organizational change.
- Pressures from working in an extremely volatile environment (i.e., health care reform, managed care, budget cuts).
- A generally low priority being placed on a long-term investment in strategic planning, vs. crisis management.

For agencies experiencing these challenges, neither the stimulus of the CBPH consortium, nor the scrutiny of their partners (or the CET), nor the small financial incentives attached to CBPH were powerful enough to initiate broad scale movement. Mainstream CBPH activity simply did not relate directly enough to the core impediments facing these health departments. For these agencies, a stronger, more targeted approach is required, one that develops leadership at top and mid-level management; brings a critical mass of experienced community people into active positions within the agencies; and engages more staff in ongoing professional development.

One of the challenges facing public health agencies espousing CBPH principles will be that of monitoring the effects of their community-based approach. Now that the rhetoric of community empowerment is commonplace, the terms "empowerment" and "capacity building" run the risk of being imprecise or meaningless, because they lack connection to action. What will keep agencies (and the rest of us) honest is a commitment to articulating which capacities are to be enhanced, monitoring progress towards those capacities, and evaluating whether power gets transferred in real terms (i.e., resources and authority).

Academic Institutions

Virtually all academic partners became engaged in CBPH as support players in their consortium. Most (but not all) also engaged in significant organizational changes as a result of CBPH. Schools that were able to use CBPH as a platform for initiating or supporting a culture of community-based public health teaching, research, and practice appeared to have had one or more of the following assets:

- Visionary faculty and administrators with previous theoretical grounding in community approaches and a philosophy that had been elaborated and tested in previous work.

- Skilled leaders who understood methods of organizational change, and who used those skills to promote the principles and practices of community-based public health -- not just the funded project -- within their own school.

- Institutions with some amount of state support (public money), or a tradition of practice in the community, appear to have had advantages over private, or otherwise highly research oriented (i.e., externally supported) institutions. (See Appendix for a table that compares the percentage of income faculty are expected to generate across CBPH academic institutions). In these latter schools, the reward systems made it difficult for faculty to commit to CBPH work.

For schools lacking these advantages, neither the stimulus of the CBPH consortium, nor the small financial incentives attached to CBPH were powerful enough to initiate institutional change. As with underengaged public health agencies, these institutions need more targeted help to increase the number of skilled faculty and administrative support for community-based practice, research, and teaching.

Positive benefits of CBPH for academic institutions include enhanced course offerings (especially in community development/organization), enhanced student placements, and collaborative research and teaching. The CBPH has generated instructive examples of team teaching, co-development of courses, and collaborative research. There is some evidence that support for community-based research, and research on community-based practice, is growing nationally.

One of the most important lessons learned from CBPH concerns student placements. Schools that have expanded their placement systems (and thereby made learning more experiential) report that a tremendous amount of coordination is involved, and that the time required of campus faculty, lay instructors, and community site mentors is quite significant. Satisfaction with the experience for all concerned appears related to the amount of coordination achieved. Schools that report greater success with placements have been able to designate staff to manage the process. Staff coordinators do such things as:

- Set up resource rooms and maintain information on community organizations and interests.
- Advertise and recruit students.
- Maintain lines of communication with community sites.

- Explore and develop relationships with new community sites.
- Assist with student or mentor orientation.
- Report to faculty task-forces and other groups.
- Trouble-shoot problems, and evaluate student placements.

While some of these tasks can be shared with student organizations, or spearheaded by faculty, problems with these modes of coordination can occur. For example, turnover in student positions, lack of continuity, and lack of incentive for faculty to commit the necessary time are common. There is evidence that when the placement process is well supported, valuable learning for students, professional development for faculty, and community benefit can occur. When the placement process is not well supported, student placements can become a real drain on CBO time and energy, and students can feel frustrated by lack of direction, or a sense that they are valued only as clerical support.

The costs of student placements can be so high, in fact, that the model should be questioned unless the institution and community go the additional step of establishing continuity between student projects, and the relevance of student involvement to long-term community interests. In this model, projects become part of a longer line of research carried out by faculty and community people conjointly, and assisted by several generations of students. This mindset turns "one shot deals" with perhaps marginal benefit for students and communities (and no impact on institutions) into meaningful programs of community problem-solving and public health research with long-term benefit for all.

Community-Based Organizations and Citizens

Community groups in the CBPH faced the challenges of: (a) mobilizing community forces at the grass-roots level to assess needs, set agendas, plan programs, and advance health status and health policy goals, and (b) understanding their university and public health practice partners' organizational values, structures, and practices, in order to help these partners enhance their missions of teaching, research, and practice. These very different and equally difficult tasks add up to a rather tall order. Some community groups had the additional challenge of learning how to collaborate across racial and cultural lines within their own community or consortium.

In assessing this initiative's impact, it's important to acknowledge that community groups came in to the CBPH at different stages of organization and development. Some had

existed for 20 years prior to the initiative, others were created after the proposal was funded in 1992. Some were umbrella collaboratives, drawing together dozens of established groups, volunteers, and leaders with prior commitments to work together. Some of these established groups also had previous experience with institutions, political and governmental leaders; they were used to "sitting at the table, speaking up, and being heard." In sum, they had some critical measures of power. Other community organizations consisted of much smaller citizen or resident groups. They had tremendous energy and growing visibility in their neighborhood, but comparatively less experience and fewer resources to draw upon.

A majority of the community partners in CBPH appeared to worked hard to build their own capacities and power base and reported gaining important skills and deriving real satisfaction with the initiative. For the newer and smaller community groups, capacity building meant recruiting volunteers, learning organizational and leadership skills, exploring the political landscape, building local projects, gaining important new contacts, getting students linked to an educational pipeline. The groups starting from this point who seemed to make the most progress appeared to have several advantages, such as:

- Diplomatic skills, in building relationships with institutional partners, rather than cutting off relationships or retreating to an "us - them" mentality when conflict arose.
- Willingness to do considerable homework in understanding their own community needs and acquiring unfamiliar skills (e.g., proposal writing, hiring/supervising staff).
- Conflict resolution skills, in building consensus among different and sometimes competing community groups within the same neighborhood or consortium.
- Either the financial resources or sanctioned time that permitted them to invest the hours needed to develop their community agenda.

These groups also may have enjoyed other things, such as:

- Institutional partners who took the time to really get to know the people and issues of concern in the neighborhood.
- Partners who had previous experience with presenting themselves as active facilitators and collaborators.
- Partners who followed up initial meetings with instances of technical assistance, support, and other tangible resources.

While most community groups were able to commit to the CBPH goals of community capacity building, fewer came into the initiative at a stage where helping institutions with

systems change made much sense. Partnering came easier when it involved community assessment or health promotion / disease prevention projects in their own neighborhood (e.g., village health worker, after-school programs). There is evidence, however, that for the community groups who joined at the beginning of the Leadership and Model Development phase, increased understanding of the broader systems change goals did occur. For more established community groups and leaders, excellent examples of their change agent work inside institutions can be cited. This includes examples of team teaching, participation on curriculum and search committees, the drafting of policy proposals, and high level networking. It also includes the less heralded, but absolutely critical task of educating professionals about community.

Implications of CBPH for community people include the following thoughts:

- Community groups have reason to be cautious about joining coalitions or collaboratives. While money is always tempting, community groups need to ask, "Is this the best use of our time and energy?" Prior to making a commitment, it is important that community groups assess both their own readiness to be partners in multi-sector initiatives and their institutional partners' purposes for involving them. The potential for co-optation remains high, as does the potential for simply being drawn into too many complicated initiatives that take away from their primary mission. Because more and more funders are mandating community involvement, and more institutions are searching for community partners, this caution needs to be vigilantly exercised.

- Successful partnerships require people from the community who have learned how to navigate institutions. Such persons connect various parts of the collaborative together and can focus the parts on a long-term, shared mission. These "bridge builders" or "boundary spanners" (from institutions as well as community) are often initially welcomed by both sides, only to be later scorned as "sell outs." While neither side can afford that (if our collective society is going to survive), the community is potentially the more immediate and greater loser, because it begins with fewer resources. It is thus in the community's best interest to develop and actively support as many bridge builders as possible.

- Maintaining a focus on problem-solving (rather than problem people) is important when the emotional investment is high. To instill a problem-solving mindset it must be

practiced religiously in public and private settings. This attitude is easiest to carry out when groups are homogeneous, small, decentralized, and the stakes are low. It is hardest when groups are diverse, when governance is by necessity layered (because of size), and when a lot of money is involved.

Mixed Groups Engaged in Partnerships

Most of the lessons learned so far that apply to partnerships in general can be found in earlier sections of this report, especially in the summary of Schmitz's presentation at the Annual CBPH Meeting, McGee Johnson's Leadership Survey, and the follow-up results of the Cost / Benefit Survey. Some of the most important lessons are reiterated below:

- A formal consortium structure is not the only vehicle for accomplishing a collaborative, community-based model of public health. It's healthy to examine the costs and benefits of a consortium approach, and to be selective about forming or joining a consortium.

- Collaboration cannot occur in the absence of accountability; some means (either formal or informal) of assuring group adherence to agreed upon values, goals, and objectives makes collaboration possible.

- Leadership needs to be shared; to ensure that, training in shared leadership models and skills needs to happen for all partners. It also needs to be more explicitly taught, along with strategies for organizational change, at the graduate level for health professionals.

- People in collaboratives are most motivated by personal and professional development reasons, and for the altruistic (goal-related) purposes related to improving aspects of their community or society. Motivations aside, most people can't afford to sustain time commitments in collaboratives without some type of financial support or release time.

- High morale is a consortium's most valued asset (Wandersman, private communication). More than money, more than given expertise, a consortium needs morale that comes from mutual trust and respect. Internal conflict is the highest cost for any group, and it is not healthy for groups to remain together if conflict cannot be resolved in a constructive manner.

- Changing engrained systems -- be they in institutions or in communities -- requires a critical mass of people. One or two people cannot change an organization. Building that critical mass is one of the most important, continuous investments needed to keep a "movement" alive.

Funders of Community-Driven, Multi-Sector Collaboratives

Funding community-driven, multi-sector collaboratives is likely to be a significant learning experience for many program officers. It may be uncomfortable because it involves a change in role, a "loss of control," and a faith in bottom-up process that not every board of trustees will understand or be patient with. As the previous sections should make clear, systems change takes many years to achieve, and collaborative structures take time and leadership skills to orchestrate. This reality requires funders to have long-range strategic planning capability, considerable resources, and a clear rationale for determining when and why to mandate marriages between unlikely partners. Some thoughts gained in observing funder / consortia relationships in this initiative are offered below.

- Failure to define "community," or to understand the myriad capacity-building needs that different community groups may have, can lead to inappropriate matches between community and institutional partners and no small amount of frustration. Capacity-building needs to take place for many community partners before they can profit from the experience of a multi-sector collaborative, or contribute to larger systems change goals. It is therefore incumbent on funders, when launching initiatives, to be clear about the goals of the initiative. If systems change is the goal, then established community organizations would make the most effective partner, because they have enough knowledge and clout to penetrate institutions. Established, successful CBOs have the capacity to move from a project focus to a systems and policy focus. If neighborhood capacity-building is the goal, then organizations and communities at all stages of development would make appropriate grantees, but the role of institutional partners shifts. Most institutions need training in how to facilitate community capacity-building and the art of "resourcing up" the community.

  One reason why the CBPH proved so challenging is that it combined both community-capacity and systems change goals in one initiative. While this is not theoretically impossible (as some consortia demonstrated), it is a real challenge. Well into the third year, the CET observed groups who were still trying to come to agreement over which

goals "were the real goals of CBPH," or couldn't figure out how to stretch their fiscal and human resources to accomplish all the goals identified.

- As the Leadership Survey found, the structure of multi-sector consortia, anchored by a single project director, needs to be reconsidered. In traditional hierarchical organizations, such a model might work best. However, in consortia where collaboration among diverse partners is the most important factor that promotes achievement of goals, such a model poses a serious hindrance, in that it creates an expectation of leadership by a single individual, rather than "leadership by many." Funders of future partnerships should anticipate not only training grantees for this model of governance, but prepare themselves to adapt their own communication and management style as well. For example, funders should:

  - Substitute the term "project coordinator" or "facilitator" for "project director" in all funder documents and communications. Emphasize the importance of a representative governance structure at the onset, and then provide training for collaborative leadership for all board leaders, members, and staff.

  - If groups are funded to "vision" or plan collaborative projects (e.g., the LMD year), request that project coordinators and evaluators be included from the onset.

  - Resist the temptation to develop one-on-one relationships with individual leaders. Establish relationships with the collaborative entity that emerges, and maintain appropriate protocols in communication.

  - Prepare for the length of time that collaborative decision-making takes by working backwards from their own organizational deadlines and allowing additional weeks for turn-around time. Having done that, funders should be clear about the steps that will or will not be taken, if consortia do not meet deadlines.

  - Make funds available for project evaluation for the purpose of informing shared leadership decisions. Expect grantees to match (to some degree) the external funds for evaluation, in order to encourage their buy-in and commitment. Make receipt of a grant contingent upon these terms. Continue to communicate expectations of project evaluation throughout the life of the initiative to promote internal accountability and learning for improvement and success.

B. Goals and Activities Scheduled for Year Four

The goal of the CET in the final year is to provide some closure to the CBPH, and to continue to search for the lessons learned for current and future partnerships in public health. For an overview of our four major strategies, see below:

- The main CET activity will be the production of the second video documentary. This film, which will be professionally produced by Grey Lizard Productions, is intended for a general audience and will be approximately one hour in length. We hope to air it on national television and to distribute it to local cable access stations. Additionally, each consortium will receive several copies for internal distribution. Research and back-ground material is being collected now. Filming will be done separately from the CET site visits, and will be scheduled during the winter and spring months of 1996. More information about the video will be forthcoming.

- The second major activity is the re-administration of the cost / benefit survey, which is scheduled for spring of 1996. This survey will again have two parallel forms: one for consortia members, the other for key leaders of the institutions and organizations comprising consortia. While the content will mirror that of the second-year survey, a small but important shift will be made in the essential question being raised. The second-year survey asked respondents to comment on the costs and benefits of participating *in their respective CBPH consortium.* The Year Four survey will ask respondents to comment on the costs and benefits *of using a community-based, public health approach.* Our intent here is to separate the consortium structure from the principles of CBPH, to better get at the contribution that a community focus brings to members' work.

- Annual site visits will take place from January through April as in preceding years. We anticipate that these visits will be shorter in length (two - three days, rather than five), and take on the tenor of an exit interview. We anticipate sending out prior to the visit a list of questions that address the key attributes listed on page (x), and asking groups for an assessment of their experiences relative to those attributes. We will be looking especially for examples of what worked and did not work, from members' perspectives, about using a community-based, collaborative approach, and what they would recommend for future partnerships.

- Last but not least, we will continue to collect indicator data and to compile CBPH totals. Individual consortium indicators will be used to confirm progress and to illustrate examples of CBPH in final written reports.

The CET remains interested, as always, in feedback from CBPH stakeholders about our process and products. We welcome all comments and suggestions, especially those that address strategies for making our materials address information needs of specific audiences. We look forward to our final year.

Appendix

List of Cluster Evaluation Reports and Products

All reports and products were conducted under the auspices of the Cluster Evaluation, Center for Urban and Regional Affiars, University of Minnesota. They can be obtained by writing the Cluster Evaluation Coordinator.

March 1993	Characteristics of Viable Organizations, As Predicted by an "Open Systems Framework" and Demonstrated in Neighborhood Block Associations, paper by Dr. Abraham Wandersman.
April 1993	Understanding Coalitions and How They Operate: An "Open Systems" Organizational Perspective, paper by Dr. Abraham Wandersman.
June 1993	The Evaluation - Policy Connection. Presentation / paper at the second annual CBPH meeting by Dr. Connie C. Schmitz.
Sept 1993	Cluster Evaluation of the Community-Based Public Health Initative: 1993 Annual Report, by Dr. Connie C. Schmitz.
July 1994	Types of Linkages Occurring in Community-Based Public Health Consortia. A preliminary tool for measuring collaboration, based on a framework by Mr. Arthur Himmelman and a content review of first-year annual CBPH reports.
July 1994	Site Visiting the Seven Consortia in the Community-Badsed Public Health Initiative (CBPH): Reflections on Year Two, paper by Dr. Connie C. Schmitz, Ms. Carol McGee Johnson, Dr. Marijo Wunderlich, and Mr. Arthur T. Himmelman.
Spring 1994	The Community-Based Public Health Initiative: Current Costs and Benefits to Member Organizations, a survey instrument developed by Dr. Connie C. Schmitz and Dr. Pat Shomacher of the Minnesota Center for Survey Research.
Summer 1994	Survey of Individual Members and Member Organizations on the Costs and Benefits of Belonging to a Community-Based Public Health Consortium, report by Dr. Connie C. Schmitz and Dr. Pat Shomacher .
Sept 1994	Bringing People to the Table: A Video Scrapbook from Year Two of the Community-Based Public Health Initiative, filmed by local videographers working at seven CBPH consortium sites. Produced and edited by Grey Lizard Productions, Inc., Minneapolis, MN.
Sept 1994	Cluster Evaluation of the Community-Based Public Health Initative: 1994 Annual Report, by Dr. Connie C. Schmitz.
Nov 1994	The Development of Standardized Indicators Across Multiple and Diverse Consortia: The Kellogg Community-Based Public Health Cluster Evaluation. Presentation / paper at the 1994 annual meeting of the American Evaluation Association by Marijo Wunderlich.
Spring 1995	The Consortium Activities Diagnostic Survey (CADS). Instrument and Users Manual by Mr. Arthur Himmelman, Dr. Michael Luxenberg, and Dr. Connie C. Schmitz.

Spring 1995	Predicting Cost/Benefit Assessments and Participation Levels in Multi-Sector Consortia in Public Health. Paper by Dr. Connie C. Schmitz, Dr. M. G. Luxenberg, and Mr. D. Truong.
Sept 1995	Reflections on Leadership in Community-Based Public Health Consortia. Paper by Ms. Carol McGee Johnson.
Sept 1995	Indigenous Health Worker Models in Community-Based Public Health Consortia. Masters in Public Health (MPH) paper by Ms. Cecilia Goetz.
Sept 1995	Cluster Evaluation of the Community-Based Public Health Initiative: 1995 Annual Report, by Dr. Connie C. Schmitz and the Cluster Evaluation Team.

Leadership Survey

CBPHI Cluster Evaluation

Spring, 1995

1. How has the project director's position been defined in the your consortium?
2. Describe your consortium's current model of leadership; that is, who are the leaders (in addition to the project director), and how is leadership managed or practiced?
3. For consortia such as yours, what do you think are the most essential kinds of knowledge that leaders need to have for the consortium to succeed?
4. Which persons (if any) do you feel bring this kind of leadership knowledge to the consortium "table?"
5. For consortia such as yours, what do you think are the most essential skills that leaders need to have for the consortium to succeed?
6. Which persons (if any) do you feel bring these leadership skills to the consortium "table?"
7. For consortia such as yours, what do you think are the most important functions and tasks that leaders need to perform for this consortium to succeed?
8. Which persons (if any) do you feel perform these leadership functions and tasks in your consortium?
9. Can you provide us with an example of where the presence of leadership knowledge, skills, or function/task helped your consortium solve a problem, or create some action or product?
10. Can you provide us with an example of where the lack of some leadership knowledge, skill, or function/task made it difficult (if not impossible) to solve a problem, or move forward on some issue?
11. What have been the main constraints that you have faced in your role as a leader in the consortium?
12. What suggestions do you have for reducing or eliminating these constraints?
13. What assets, conditions, or other factors have helped you perform in the job most?
14. Do you have any final comments related to leadership in your consortium?

Consortium Activities Diagnostic Survey

CADS

A Tool to Understand the Ways that Groups Work Together

Developed by

Arthur T. Himmelman
Michael G. Luxenberg, Ph.D.
Constance C. Schmitz, Ph.D.

April, 1995

PILOT FORM A
Version 2.2

Introduction

The Consortium Activities Diagnostic Survey (CADS) provides those working in consortia with a tool to assess the degree to which their working relationships reflect one of more of the four basic working together strategies: networking, coordinating, cooperating, and collaborating. CADS' primary purpose is to help consortia partners determine how they can better employ the most appropriate and effective working relationships, depending on, among other variables, levels of trust, shared values, and the strength of common commitments.

CADS defines the four strategies along a developmental continuum as follows: *

(1) Networking: exchanging information for mutual benefit;

(2) Coordinating: exchanging information and altering activities for mutual benefit and a common purpose;

(3) Cooperating: exchanging information, altering activities, and sharing resources for mutual benefit and a common purpose; and

(4) Collaborating: exchanging information, altering activities, sharing resources, and enhancing each other's capacity for mutual benefit and a common purpose.

Instructions

Four fictitious consortia (North East, West, and South, respectively) are created to illustrate actions that the members of their consortium, coalition or similar group are likely to take when engaging in these strategies. Brief summaries of these consortia are provided to help the reader understand how the four strategies might be employed as consortia pursue their particular mission, goals, and objectives. In responding to the survey questions, please review each activity described under each illustrative consortium as it relates to your group. ***Then circle the number representing the frequency with which you feel that your consortium or group engages in the listed action.*** Also, please try to base your responses to the survey on specific examples rather than general impressions of activities when responding to each item. At the bottom of each page you are requested to provide one additional example of the corresponding strategy in your consortium or group.

Please Note

It is important to emphasize that each of the four strategies may be the best for particular circumstances and CADS users should not assume that their consortium is not successful if it does not employ the most complex of the four strategies.

* Definitions taken from Himmelman, A.T. (1992). Communities Working Collaboratively for a Change. Minneapolis, MN, pp. 7-8.

NORTH

The North Consortium is engaged in **networking (exchanging information for mutual benefit).** Meetings of the North Consortium are held on a monthly basis. During this time, members exchange information about health care services and programs that might be of interest to others. The members also exchange newsletters so that partners can keep current of each others' activities and send each other notices of speakers who will be addressing topics of mutual interest.

(Please circle one number for each item using the following response format.)

How often do partners in <u>your</u> group *exchange* . . .

	Never	Seldom	Some-times	Often	Always	Unsure NA
1. Information about program activities	1	2	3	4	5	0
2. Survey research data	1	2	3	4	5	0
3. Information about funding sources	1	2	3	4	5	0
4. Information about job opportunities	1	2	3	4	5	0
5. Information about meetings, conferences	1	2	3	4	5	0
6. Publications and telephone directories	1	2	3	4	5	0
7. Information about computer networks	1	2	3	4	5	0
8. Information about databases	1	2	3	4	5	0
9. Conversation over a common meal	1	2	3	4	5	0
10. Information about trainers, speakers, or consultants	1	2	3	4	5	0
11. Information about office equipment or operating needs	1	2	3	4	5	0
12. Information about organizational development opportunities	1	2	3	4	5	0
13. Information via electronic mail	1	2	3	4	5	0
14. Information via conference calls	1	2	3	4	5	0
15. Information through video or slides	1	2	3	4	5	0
16. Information through computer networks	1	2	3	4	5	0
17. Annual reports	1	2	3	4	5	0
18. Strategic plans	1	2	3	4	5	0
19. Listings of boards of directors	1	2	3	4	5	0
20. Lessons learned from evaluations	1	2	3	4	5	0

Give an example that illustrates <u>networking</u> in your group: _____

_____

_____

EAST

The East Consortium is engaged in **networking and coordinating (exchanging information and altering activities for mutual benefit).** Several members have reviewed their program activity schedules and have altered the times they offer programs to better meet the needs of common communities that they serve. The members also have revised information and tracking forms to ask as many questions in common as possible, so that people involved with their programs find the paperwork easier, less redundant, and less confusing. In addition, this allows the partners to do joint follow-up and evaluation.

(Please circle one number for each item using the following response format.)

How often do partners in <u>your</u> group *change or alter:*

	Never	Seldom	Some-times	Often	Always	Unsure NA
1. Dates for conferences, meetings, or events based on similar activities of others	1	2	3	4	5	0
2. Plans so that a combined event could be held with other organizations	1	2	3	4	5	0
3. Fund raising plans based on activities of other organizations	1	2	3	4	5	0
4. Transportation schedules to provide better service	1	2	3	4	5	0
5. The way language and jargon is used to better coordinate with other organizations or programs	1	2	3	4	5	0
6. Program activities to expand the range of service	1	2	3	4	5	0
7. Program activities so that needless duplication of programs is reduced	1	2	3	4	5	0
8. Program delivery so that activities occur at the best locations	1	2	3	4	5	0
9. Program calendars, for the sake of compatibility	1	2	3	4	5	0
10. Strategic plans, to reduce competition	1	2	3	4	5	0
11. Target populations served	1	2	3	4	5	0
12. Program focus, for the benefit of the group	1	2	3	4	5	0
13. Software, for compatibility	1	2	3	4	5	0
14. Hardware purchases, for compatibility	1	2	3	4	5	0
15. Communications programs	1	2	3	4	5	0
16. E-mail services	1	2	3	4	5	0
17. Definitions of program participants, actors	1	2	3	4	5	0
18. Data collection forms	1	2	3	4	5	0
19. Geographic focus of activities	1	2	3	4	5	0
20. Plans to recruit new members	1	2	3	4	5	0

Give an example that illustrates <u>coordination</u> in your group: _____

_____

_____

WEST

The West Consortium is engaged in **networking, coordinating, and cooperation (exchanging information, altering activities, and sharing resources for mutual benefit and a common purpose).** West Consortium members have rented office space together and hold meetings at this site. Members were able to afford the rent because they sought and received a grant from a local funding source that partners also tap for their own program support. Such cooperation was possible because for some time, members have been sharing information about funding sources and altering activities to better coordinate activities in a common area of interest.

(Please circle one number for each item using the following response format.)

How often do partners in <u>your</u> group *share:*

	Never	Seldom	Some-times	Often	Always	Unsure NA
1. Office or meeting spaces	1	2	3	4	5	0
2. Staffing or personnel	1	2	3	4	5	0
3. Responsibility for securing funding resources	1	2	3	4	5	0
4. Funding resources	1	2	3	4	5	0
5. Responsibility for providing program services	1	2	3	4	5	0
6. Equipment or furniture	1	2	3	4	5	0
7. Computers or other hardware	1	2	3	4	5	0
8. Software licenses	1	2	3	4	5	0
9. Databases	1	2	3	4	5	0
10. Speakers, trainers, or consultants	1	2	3	4	5	0
11. Responsibility for providing transportation	1	2	3	4	5	0
12. Recognition or awards ceremonies	1	2	3	4	5	0
13. Legal counsel	1	2	3	4	5	0
14. Technical assistance support	1	2	3	4	5	0
15. Costs for providing programs	1	2	3	4	5	0
16. Responsibility for recruitment efforts	1	2	3	4	5	0
17. Leadership responsibilities	1	2	3	4	5	0
18. Management responsibilities	1	2	3	4	5	0
19. Responsibility for preparing required reports	1	2	3	4	5	0
20. Responsibility for monitoring and evaluation	1	2	3	4	5	0

Give an example that illustrates <u>cooperation</u> in your group: _____

_____

_____

SOUTH

The South Consortium is engaged in **networking, coordinating, cooperation, and collaboration (exchanging information, altering activities, sharing resources, and enhancing each other's capacity for mutual benefit and a common purpose).** South Consortium members have helped each other improve data gathering techniques by offering staff development workshops for each other in areas of their particular expertise. Also, members have offered each other proposal writing training so that all members could increase their ability to seek and receive funds. Members routinely visit each other's programs to offer advice on how programs can be improved. Many of their activities are centered on how members can help each other become the best they can be in meeting their common purpose.

(Please circle one number for each item using the following response format.)

How often do partners in <u>your</u> group *enhance each other's capacity by helping each other:*

	Never	Seldom	Some-times	Often	Always	Unsure NA
1. Better identify funding sources	1	2	3	4	5	0
2. Better write or prepare funding proposals	1	2	3	4	5	0
3. Better design data collection instruments	1	2	3	4	5	0
4. Improve skills through professional development	1	2	3	4	5	0
5. Better write or prepare newsletters, reports, etc.	1	2	3	4	5	0
6. Improve the design of programs serving a common purpose	1	2	3	4	5	0
7. Improve the implementation of programs serving a common purpose	1	2	3	4	5	0
8. Accomplish specific kinds of systems change	1	2	3	4	5	0
9. Secure the passage of legislation	1	2	3	4	5	0
10. Develop training or curriculum materials	1	2	3	4	5	0
11. Improve the effectiveness of boards of directors	1	2	3	4	5	0
12. Upgrade technology skills	1	2	3	4	5	0
13. Upgrade computer systems by trading components	1	2	3	4	5	0
14. Better recruit and retain new partners	1	2	3	4	5	0
15. Base activities on the assets rather than deficits of communities	1	2	3	4	5	0
16. Empower the people most affected by common activities	1	2	3	4	5	0
17. Increase diversity and inclusiveness in activities	1	2	3	4	5	0
18. Use community organizing to increase community empowerment	1	2	3	4	5	0
19. Better understand, use, or change rules and regulations affecting programs	1	2	3	4	5	0
20. Evaluate change processes and outcomes	1	2	3	4	5	0

Give an example that illustrates <u>collaboration</u> in your group: _____

_____

Consortium Activities Diagnostic Survey

CADS

USER'S GUIDE

A Tool to Understand the Ways that Groups Work Together

Developed by

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Developed for
the Cluster Evaluation
of the Community-Based Public Health Initiative
funded by the W. K. Kellogg Foundation

April, 1995

PILOT FORM A
Version 2.2

Background

The Consortium Activities Diagnostic Survey (CADS) is a tool to help people understand the ways in which members of groups (such as consortia and coalitions) work together. It does this by asking members to report the frequency with which they engage in activities related to four different working together strategies: networking, coordinating, cooperating, and collaborating. While groups are likely to use aspects of each strategy concurrently, the CADS considers each strategy a distinct step or level in a developmental continuum. Based on definitions provided by Himmelman [1], these strategies can be clarified as:

1) **Networking** Exchanging information for mutual benefit

2) **Coordinating** Exchanging information and altering activities for mutual benefit and a common purpose

3) **Cooperating** Exchanging information, altering activities, and sharing resources for mutual benefit and a common purpose

4) **Collaborating** Exchanging information, altering activities, sharing resources, and enhancing each other's capacity for mutual benefit and a common purpose

CADS creates four fictitious consortia (North, East, West, and South) to illustrate actions that their members are likely to take when networking, coordinating, cooperating, and collaborating.

Who Could Use CADS

CADS was developed for multi-sector consortia participating in a public health initiative funded by a private foundation. These consortia are umbrella organizations made up of many partners representing academe, government agencies, and community-based organizations, among other groups. CADS is a tool for any consortium or coalition that has several constituencies or organizations that are trying to work together for a common purpose and want to better understand their interactions.

[1] Himmelman, A.T. (1992). Communities Working Collaboratively for a Change. Minneapolis, MN, pp. 7-8.

How to Use CADS

Selecting the Unit of Analysis and Survey Participants. CADS can be used to diagnose the ways in which an entire group works together (i.e., at the whole consortium level), or the ways in which a smaller subset of partners works together (i.e., at the task force, team, committee, or site level). Depending on the desired unit of analysis, the people asked to complete the CADS will differ. If the ways in which the entire group works together is of interest, then members who can be expected to have a "global view" of the whole group should be asked to complete the survey. This may include every member of the group. If the group is very large, however, and comprised of separate components, i.e. working groups or committees, then it would be best to give CADS only to those members participating in the central governing body (i.e., representatives on a steering committee). If the ways in which a smaller subset of partners works together is of interest, then only the members of that subset should complete the survey (i.e., representatives of the team, site, committee, etc.).

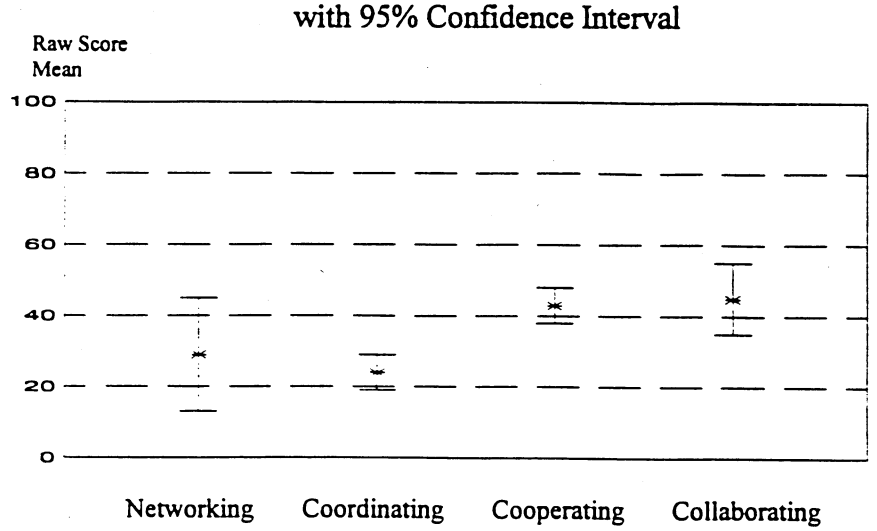
Opportunities to Use CADS. This is a tool for learning and evaluation. It can be used as a one-time only diagnostic instrument, or as a repeated measure to assess change over time. Depending on the group, CADS could be used as part of a team building exercise or planning effort. CADS could also provide information relevant for a self-monitoring (internal) evaluation. It could also be used by external evaluators working with multiple groups within a larger grant effort.

Completing the CADS. CADS is a four-page survey consisting of 80 scaled items. It takes approximately 20 minutes to complete. Respondents are anonymous. To complete the survey, respondents first read the description of the fictitious consortium and then estimate the frequency with which members of their group interact in the ways listed. There are no "right" or "wrong" answers, as the responses are personal estimates of group behavior, as observed or experienced by the individual responding. If the respondent feels the listed activity is not applicable, or is unsure that it has taken place (or the extent to which it has taken place), then "Unsure/Not Applicable" should be marked.

Scoring the CADS. Two kinds of summary statistics are of interest: item scores (and means) and scale scores (and means). [Note: "Unsure/NA responses are not included in the scoring of CADS.] To examine individual items and compare group responses to them, respondents' scores for each item should be summed and averaged. Thus, each item should have a "group" average. In this way, for example, a group may learn that for the "Networking" strategy, the members

often "exchange information about program activities at regular meetings," but rarely "exchange information about survey or statistical information." The more important outcomes of interest may be the group responses to the four separate strategies. To examine these results, a scale total is derived for each respondent for each scale. (A scale total is the simple sum of numbers circled by a respondent, excluding Unsure/NA.) After calculating a scale score for each respondent, the scores can be combined and averaged for a group mean. In this way, a group can compare the level of activity across strategies of interaction. Indices of central tendency should be augmented with indices of variability to help understand the congruity of perceptions in a group. (See the illustrative graph below.)

Group Mean for Each Strategy
with 95% Confidence Interval



Interpreting the CADS. It is important to emphasize that each of the four strategies reflects many good, constructive linkages between group members. Depending upon the history and circumstances of a particular group, one strategy of interaction may be more appropriate than another. CADS users should not assume that their group is not successful if it does not employ the most complex strategy. Rather, the information can help groups:

- Understand their primary strategies of interaction
- Discuss potential ways in which interaction can be broadened or increased
- Check to see whether all members of a group share the same perceptions about the interactions
- See whether interactions increase over time, or the primary strategy of interaction shifts

Permission to Use CADS

Although developed for use with the Community-Based Public Health Initiative funded by the W. K. Kellogg Foundation in 1992, CADS can be photocopied and used by other groups without obtaining written permission from the authors. In reporting results, users should use the following credit line:

> Himmelman, A. T., Luxenberg, M. G., and Schmitz, C. C. (1995). Consortium Activities Diagnostic Survey (CADS): A Tool to Understand the Ways that Groups Work Together. University of Minnesota, Center for Urban and Regional Affairs, Minneapolis, MN.

Notable changes in the (x?) **public health organizations** include the following:

- 6 agencies have developed strategies to increase inter-agency communication for improved work with the community
- 8 agencies have created new programs or areas of activity
- 6 agencies have developed new, or revitalized existing community advisory boards
- 5 agencies have reorganized to better serve their communities
- 5 agencies have developed or improved communication loops with community groups to better reflect input and feedback relevant to data collection and sharing
- (?) revision of mission statements, goals or objectives to reflect CBPH philosophy

Notable changes in the 30 **community-based organizations** include the following:

- 23 CBOs have developed new programs or activities
- 11 CBOs have been able to expand their membership, or enhance their community representation
- 10 CBOs have developed or improved their board structure, mission, goals or objectives
- 4 CBOs have acquired their 501(c)3 non-profit status

Course Development/Revision

Alot of the academic partners' energy in the CBPH has gone into the development or revision of courses. A total of 69 courses have been developed or revised to better reflect CBPH philosophy, content or strategies. A review of the courses by title suggests that the content of these courses consists mostly of . . .

Student Involvement

Because more courses have been revised (n = 43) than developed from scratch (n = 26), many more students (n = 2,020) have been affected by course revisions than by new course offerings (n = 455). In addition to enhancing the in-class experience for students, a number of efforts have been reported to enhance student involvement outside the classroom. Approximately 675 students have participated in 31 different field experiences related to their courses; 258 students have been assigned to 133 different practica or internships related to their degree; and 89 students have received stipends as graduate research assistants working with CBPH consortia or on CBPH activities.

Diversity

"Upward mobility" for community residents and minority students has been a consistent goal for many consortia. Of the information reported to date, the largest influx is seen in the number of community/minority individuals admitted to academic institutions (n = 107). It is not possible to know how much influence the CBPH had in the admission of these students. Additionally, 19 new faculty of color, or faculty from targeted communities, have been hired by CBPH schools. Forty-six new staff of color, or staff from targeted communities, have been hired. Most of these staff have been hired either by the academic partner institution (n = 19), or by a community-based organization (n = 20).

"Cross Cultural" Exchanges

Many consortia have reported that much of the work of CBPH occurs on an individual, one-to-one basis, when partners take part in activities occurring in each other's cultures or organizations. Consortia have reported numerous exchanges that represent new or strengthened linkages between partners who previously did not work together. Most of the exchanges taking place appear to be occurring between community and university partners, with greatest potential systems change occurring for the university. To date:

* 82 community members have served as guest lecturers in university courses
* 11 community members have serves as co-instructors or co-designers of a university course
* 59 community members have precepted students in the community setting
* 37 community members have served on academic committees
* 29 academic members have taught courses in the community setting
* 24 academic members have served on CBO boards
* 29 academic members have served in the community
* 9 academic members have served on health advisory boards
* 41 public health practice members have guest lectured in university courses
* 34 public health practice members have precepted students in community settings
* 14 public health practice members have served on academic committees
* 8 public health practice members have served as co-instructors or co-designers of a university course
* 24 community members have served on health agency boards, committees
* 10 public health practice members have served on CBO boards

Research/Evaluation

Profesional presentations, case studies by consortium partners, and student studies all have been reported, and are counted with the understanding that these products will be disseminated to external audiences. Twenty-one studies completed during the first two and one half years of the initiative have been reported as related in some way to CBPH activities. Seventy-one authors were involved in these studies.

Review of Indicators of Consortium Activity and Progress

(Numbers are cummulative; they reflect activity dating
from October, 1992, through March, 1995)

Activities Affecting CBPH Communities

Youth Activities

Concern for youth has been an important area of focus since the beginning of the CBPH for most consortia, with all seven consortia reporting some type of youth activities. To date, 65 youth programs or projects have been supported by CBPH, affecting an estimated 5,882 kids. Activities vary in scope, duration, and amount of effort. Examples include canoe racing, one-on-one mentorships with adult role models, after school tutoring, health career clubs, and participation in health promotion fairs.

Community-Based Health Workers

The category includes both indigenous health workers (IHWs) and health outreach workers employed at health departments. Most consortia have chosen to develop the IHW model. As seen in Cecie Goetz's descriptive study, the IHW terms has been interpreted broadly by those reporting data. The IHW role varies from an emphasis on community development and community organizing to more targeted health service work such as TB control. Four of the five consortia using IHWs view this effort as a consortium-wide strategy for CBPH. Approximately 38 training efforts have taken place to date, with 293 participants and roughly 142 (48%) trainees still active.

Health Related Efforts

Many health related activities have been reported in the indicators forms, but these efforts remain among the least amenable to discrete classification within and across consortia. Almost 200 different kinds of health related efforts were reported as occurring in CBPH communities with approximately 18,000 people involved or affected. These activities include community health assessments, health campaigns, health education efforts, and specific health services such as screenings.

Community Development Activities

In an effort to build communities, consortia have been engaging in a variety of community development and mobilization activities. As with health related efforts, the range of activities are numerous and less easily quantified by our definitions or aggregated. The greatest amount of activity reported to date is community mobilization, with 66 reported efforts and approximately 800 participants. These activities included drug patrols, petition drives, neighborhood clean-ups, and documenting complaints on problem liquor stores. Other efforts included public meetings, forums or summits (45 efforts), and training workshops in community development and other non-health related skills (41 efforts). All together, about 15,000 people have been involved in or affected by 182 community development activities.

Activities Affecting Organizations

Personal Development

Strategies to develop the personal and professional skills of academic faculty, staff and students, public health practice staff, and staff within community-based organizations have occurred in all consortia. The current number of participants affected to date is especially high for Public Health Practice staff. A common area of development across all groups is that of cultural diversity training. To date:

- 17 opportunities have been made available to public health practice staff. Examples include in-service training around issues such as cultural competency, working in the community, and a community-based approach to public health. Approximately 650 participants have been involved.
- 29 opportunities have been made available for academic members. Examples include workshops and seminars on cultural diversity, community-based research, teaching and service, and preparation for community field work. Approximately 500 participants have been involved.
- 28 opportunities have been made available for staff of community based organizations involved with the CBPH. Approximately 230 participants have engaged in a range of activities including cultural diversity workshops, board and leadership training.
- Some training and development opportunities were not designed for a single CBPH constituency, but for mixed groups within a consortium. Sixteen such kinds of opportunities have occurred since the beginning of the CBPH, engaging roughly 470 participants.

Institutional Changes

Institutional changes to support CBPH have been reported most frequently to date by community organizations (n = 53), with the most prevalent change being that of the development of new programs or activities. A significant amount of institutional change efforts have also been reported by academic institutions (n = 40) and public health practice organizations (n = 40).

Notable changes in the (x?) **academic** institutions include the following:

- 15 new positions have been created to support CBPH philosophy
- 5 schools attribute curriculum review or revision in some way to CBPH
- 4 schools have created a new CBPH specialty or concentration
- 4 schools have developed new principles for community-based research, to be used as guidelines and protocols for conducting and publishing such research
- 2 schools have made changes in their tenure policy or merit review criteria to reflect community-based practice or service

Resources Generated

New grants are counted as either core or spin-off depending on whether they support the CBPH consortium work of two or more partners, versus new monies that went to primarily support only one partner. As reported earlier, partners continue to be much more successful in obtaining spin-off grants than in generating core grants for the consortium. To date:

- CBPH consortia have obtained 20 new grants totaling $494,537 to strengthen their core group work. Of the three partners, the community has generated most of this new money (largely due to the Kellogg challenge grant offered in 1994), with 11 grants that totaled $203,347. The academic partners and public health practice partners were fiscal agents of 4 core grants each; these grants totaled $155,500 and $129,690, respectively.

- CBPH partners have brought in additional dollars ($8,323,937) to support spin-off activities. While these grants may not be directly attributed to the consortium, or be used to sustain the consortium as a whole, they may effectively support a particular partner's ability to participate in the consortium.

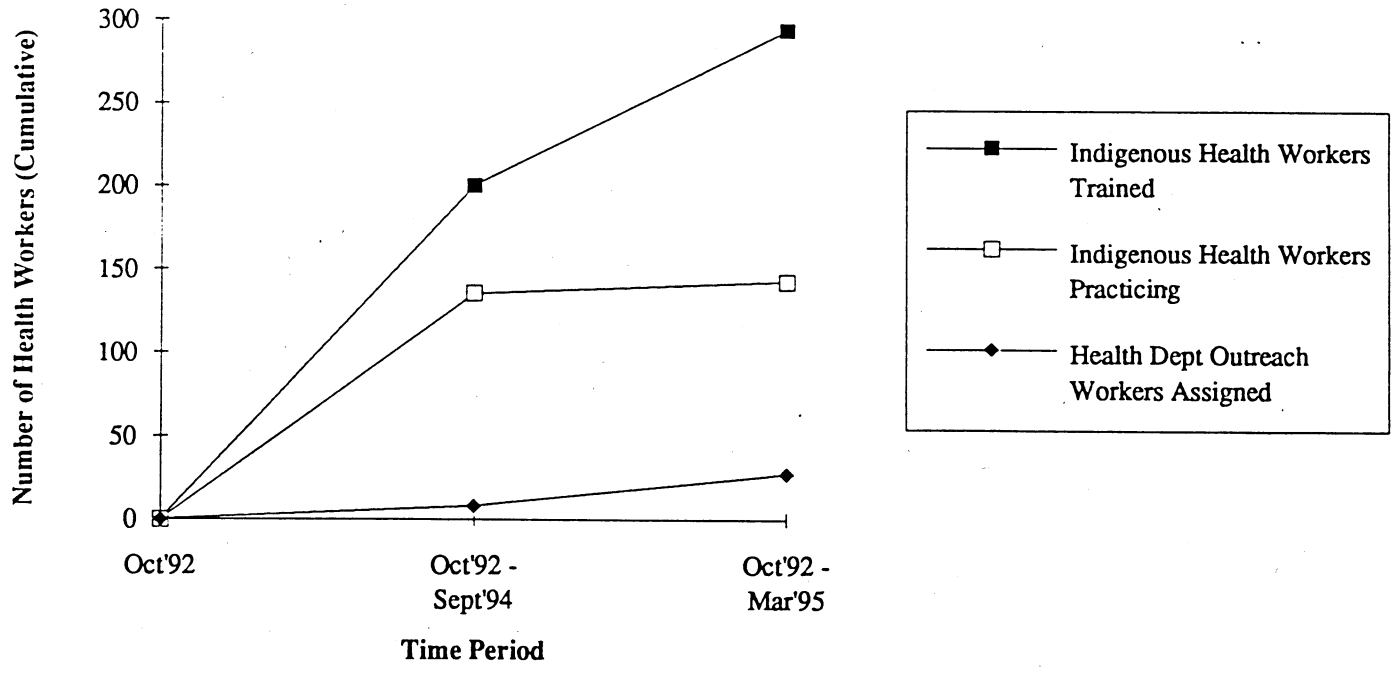
Policy

We added a category "policy influentials" in the second round of indicator collection to document consortia efforts to bring key players into the policy making process. Fifteen individuals have been reported in this category, to date. Sixteen examples of strategies to to educate people (including students, partners, and the public) about policy and policy change have been reported. Thirteen health policies have been targeted by consortia for development or change. Six institutional or other policies have been targeted by consortia for development or change. Seven actual policy products, including new state legislation, have been reported.

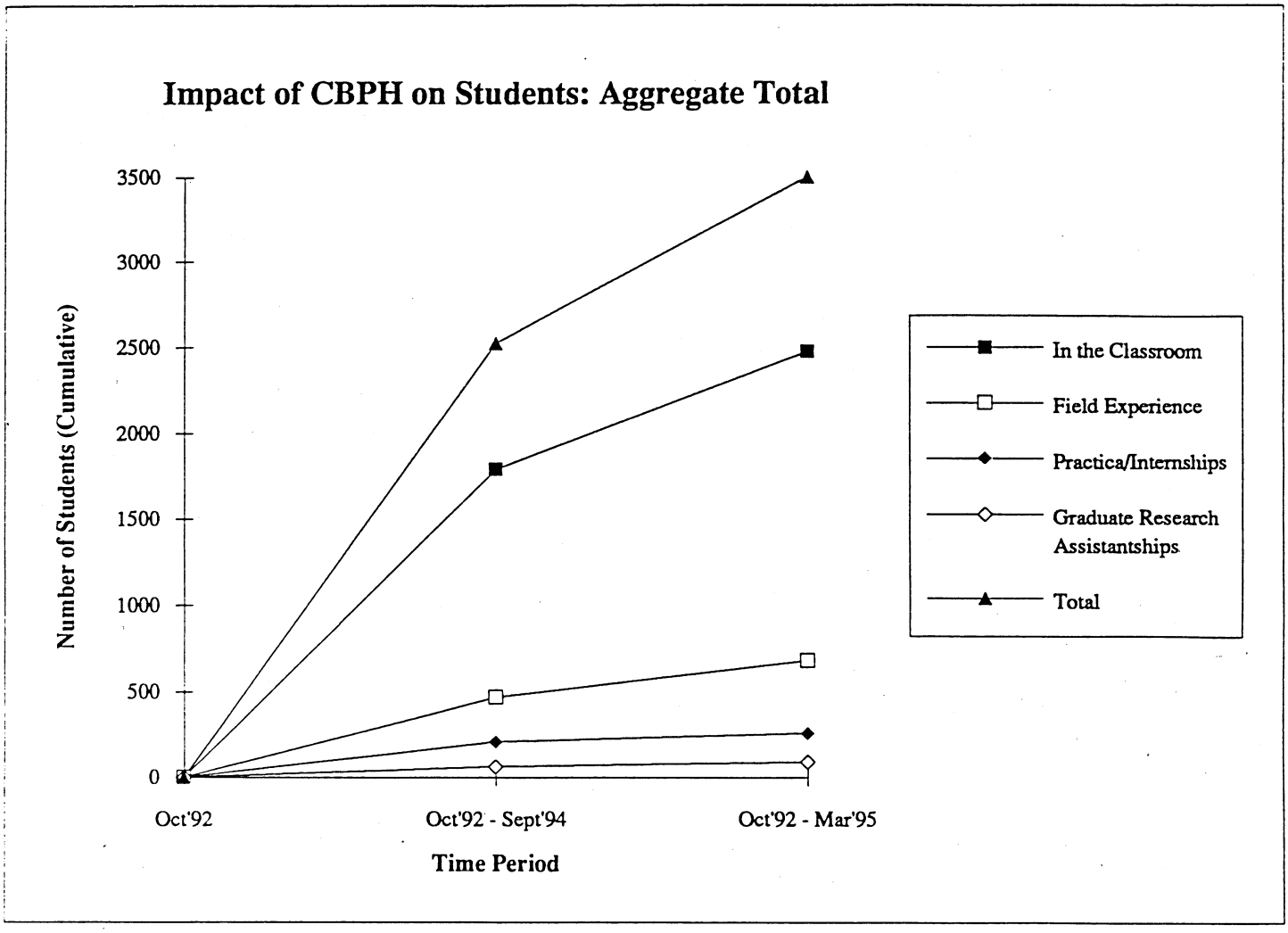
All CBPH Consortia

Activities Affecting Communities	1992-1994		Oct'94-Mar'95		Oct'92-Mar'95	
Youth Activities	# Activ.	# Part.	# Activ.	# Part.	# Activ.	# Part.
Total	37	3,188	28	2,694	65	5,882
Health Worker Activities	# Efforts	# Part.	# Efforts	# Part.	# Efforts	# Part.
Indigenous	18		20		38	
Training		200		93		293
Practicing		135				142
Health Department Outreach		8		19		27
Health-Related Efforts	# Efforts	# Recip.	# Efforts	# Recip.	# Efforts	# Recip.
Assessment	20		12		32	
Campaigns	17	5,025	39	3,853	56	8,878
Education Seminars	28	331	28	799	56	1,130
Specialized Services	11	731	12	2,272	23	3,003
Other	15	5,580	7		22	5,580
Total	**91**	**11,667**	**98**	**6,924**	**189**	**18,591**
Community Development Activities	# Efforts	# Recip.	# Efforts	# Recip.	# Efforts	# Recip.
Information blitzes	9	3,237	13	6,450	22	9,687
Meetings, forums, summits	29	1,727	16	1,734	45	3,461
Training/educational workshops	29	990	12	487	41	1,477
Mobilization Efforts	52	120	14	763	66	883
Other	4	100	4	157	8	257
Total	**123**	**6,174**	**59**	**9,591**	**182**	**15,765**

Impact of CBPH on Health Worker Activities in All Consortia



Institutional Changes: Aggregate Total	1992-1994		Oct'94 - Mar'95		Oct'92 - Mar'95	
Academic Setting						
Curriculum review, evaluation, or revision	3		2		5	
Creation of interdivisional curricula/joint degree	1		0		1	
Creation of a new CBPH specialty/concentration	4		0		4	
Development of new principles or protocols for CBPH research	4		0		4	
Creation of new positions to support CBPH philosophy	13		2		15	
Change in tenure policy rewarding CBPH research/teaching/service	2		0		2	
Other changes	6		3		9	
Total	**33**		**7**		**40**	
Course Development and Revision	#	# Part.	#	# Part.	#	# Part.
Courses Developed	22	357	4	98	26	455
Courses Revised	29	1431	14	589	43	2020
Total	**51**	**1788**	**18**	**687**	**69**	**2475**
Student Involvement	#	# Part.	#	# Part.	#	# Part.
Course related field experiences	20	464	11	214	31	678
Degree related practica/internships	120	207	13	51	133	258
Graduate research assistantships	63	63	26	26	89	89
Total	**203**	**734**	**50**	**291**	**253**	**1025**
Public Health Practice Setting						
Development/revision of practices to include communication loops	2		3		5	
Revision of mission statements, goals, objectives	2		0		2	
Reorganization of departments, divisions, or staffing	5		0		5	
New strategies to increase inter-agency communication	4		2		6	
Development of new programs and activities	6		2		8	
Creation of community advisory board	5		1		6	
Other changes	7		1		8	
Total	**31**		**9**		**40**	
Community-Based Organization/Coalition Setting						
Development of new programs, activities, projects	20		3		23	
Expansion of membership, community representation	8		3		11	
Development of board structure, mission, goals and objectives	9		1		10	
Acquisition of 501(C) 3 Non-profit status	4		0		4	
Other changes	2		3		5	
Total	**43**		**10**		**53**	
Professional Development	# Efforts	# Part.	# Efforts	# Part.	# Efforts	# Part.
Academe (faculty, staff & students)	14	195	15	299	29	494
Public Health Practice	12	581	5	71	17	652
Community-Based Organization	11	180	17	49	28	229
Mixed Group (Academe, PHP & CBO)	10	246	6	223	16	469
Total	**47**	**1202**	**43**	**642**	**90**	**1844**


Impact of CBPH on Students: Aggregate Total
Number of Students (Cumulative)
3500
3000
2500
2000
1500
1000
500
0
Oct'92
Oct'92 - Sept'94
Oct'92 - Mar'95
Time Period
In the Classroom
Field Experience
Practica/Internships
Graduate Research Assistantships
Total

Percentage of Salary that CBPH Faculty in Schools of Public Health are Required, Expected, Encouraged, or Typically Bring In From Outside Sources

	External Support Required
California	
UC Berkeley -- public university, land grant	0%
Georgia	
Emory -- private university	
Faculty in Center for Public Health Practice	100%
Other faculty in SPH, after two years	60%
To balance budget, school needs faculty to bring in	75%
Morehouse -- private university	
Maryland	
Johns Hopkins -- private university	50% academic year 70% annually
Varies from 0% to 100%, depending on individual faculty and chair, negotiable; three sources of income are endowment, tuition, and external grants.	
Massachusetts	
University of MA -- public, land grant university Faculty typically bring in external $ for summer support	0% academic year
Michigan	
University of MI -- public, **not** a land grant university	0% required 25% - 40% common
Everyone is on hard money for academic year; faculty typically bring in external $ for summer support.	
North Carolina	
University of NC -- public, "state assisted" but **not** land grant university	mean = 33% typical range = 30% - 50%
Varies, depending on individual faculty and chair; 70% of SPH's annual budget comes from external sources.	
Washington	
University of WA -- public university	75% - 85%

Percent of faculty members who receive some financial support for their work in CBPH = 35%